the magazine for family therapy and systemic practice in the UK

Context

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International NVR: Practice and participation

the magazine for family therapy and systemic practice in the UK

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Issue Editors: Rav Khela and Joanne Buchmüller
Acting General Editor: Ged Smith
Email: ged59@hotmail.com

AFT-Context Publishing Group: Liz Burns, Chip Chimera, Stuart Delve, John Hills, Lauren Hills, Joanne Hipplewith, Marie McGovern, Dimitris Mouzas, Carole Payne, Ged Smith and Yoko Totsuka.

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Email: calcock@wiley.com

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Enquiries about subscriptions to Context should be directed to the AFT office (contact details below).

Chairperson of AFT: Erica Widdowson
Contact via the AFT office (contact details below).

AFT Office: 7 Executive Suite, St James Business Centre, Wilderspool Causeway, Warrington WA4 6PS.
Tel/Fax: 01925 444414
Email: mail@aft.org.uk

Website: www.aft.org.uk

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Editorial

Rav Khela and Joanne Buchmüller

The co-editors would like to pay tribute to Brian Cade for his contributions and passion for Context over the years. We were fortunate to have had his involvement on this issue and he will be sadly missed.

We would like to thank Louise Norris for all her support during this difficult time and working extremely hard to ensure that this issue has been a success.

Non-violent resistance (NVR) has flourished worldwide since the previous special issue of *Context* – 'Non-violent resistance therapy', edited by Alex Millham in April 2014. Inspired by the socio-political doctrine of non-violent resistance and the work of influential figures such as Gandhi, Luther King and Parks, as well as the writing of Gene Sharp (1973), NVR has become a distinctive model that stands firmly on its own two feet and therefore, in this issue you will see NVR used as an abbreviation throughout. This issue is not intended as an introduction to the model, (The excellent April 2014 issue is available via the AFT website) but those with an interest in the fundamentals of the model will find helpful information at www.haimomer-nvr.com or on the Oxleas website – oxleas.nhs.uk

Haim Omer (psychologist and professor emeritus at Tel-Aviv University) is credited with originally developing NVR in 1999. He writes in this issue about how his ideas have developed over time and of the many classic systemic masters who have influenced him.

After training with Omer, Peter Jakob (psychologist and family therapist) first brought NVR to the UK in 2001. From 2005 onwards Elisabeth Heismann and Liz Day (both systemic therapists) developed their own NVR approach within the Oxleas NHS Trust and Oxleas continues to support the practice of NVR today. Jakob has developed and written widely about his trauma-focused NVR approach but writes here about his integration of narrative and NVR ideas.

No one could have predicted how NVR would be adapted and expanded by practitioners across the globe. It is proving to be helpful in systemic work with presenting issues such as eating disorders, psychosis and more, and you will find articles explaining why in this issue. From Belgium, Kerstin Thys and Annelies Huybrechts write about NVR in a residential context with refugee teenage girls, adding a rich cultural dimension. From Israel, Uri Weinblatt introduces 'shame regulation'. Dan Dulberger (family and marital therapist) applies a reflexive lens to Canadian culture, NVR and the connections with systemic psychotherapy.

Over time NVR has united classical and contemporary systemic thinking. Nicky Maund and Lydia Stafford illustrate this in their article on NVR and 'coordinated management of meaning' (Cronen & Pearce, 1976). John Burnham, Beki Brain and Juanella (graduate parent pseudonym) write about the 'patterns that connect' (Bateson, 1979) NVR, 'multi-family therapy' (Asen & Scholz, 2010) and 'approach – method – technique' (Burnham, 1992).

NVR unites colleagues from different cultures and working contexts: practitioners from social care, psychology, psychotherapy etc. train alongside each other. We (Rav and Jo) met on such a training in Sheffield: two systemic family therapists, one from the West Midlands, one from South Wales, both with a passion for NVR and a desire to bring together the international NVR voices and share this with the systemic community. Karl Tomm in Calgary, Canada and John Burnham in Birmingham, England begin this issue explaining how they have incorporated NVR into their practice. We hope that this will encourage others to do the same.

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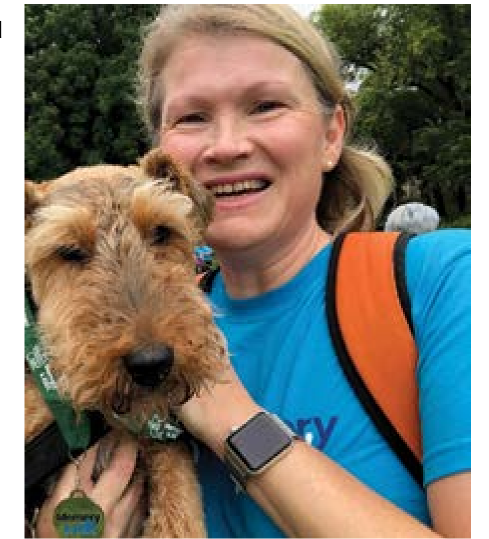
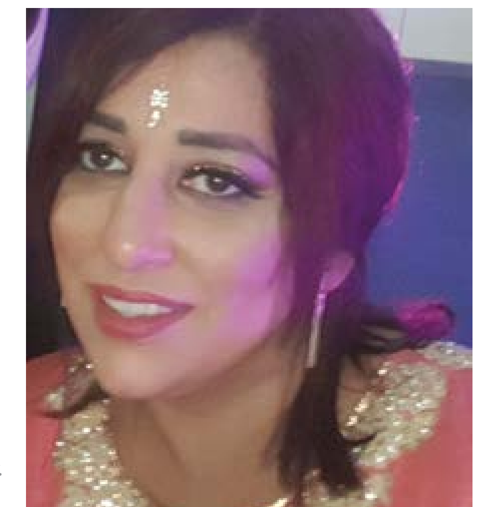


Joanne Buchmüller is currently practising as a specialist family and systemic psychotherapist in tier 4 CAMHS in her home patch of South Wales. She is an NVR associate and trainer for Partnership Projects, UK. She is co-author of *Family Therapy Skills and Techniques in Action* (2018) and is currently writing a parent and practitioner introductory guide to NVR. When not out walking with her family and dog, Jo can be contacted at joannebuchmuller@me.com



Rav Khela is a consultant family and systemic psychotherapist and accredited NVR practitioner and supervisor in both systemic psychotherapy and NVR. Rav is head of family therapy in a tier 3 CAMH service in the Black Country. She is a pioneer in developing a project connecting NVR within health, education and social care. Rav was a board director and trustee of AFT from October 2018 to February 2021, contributing to the expansion of systemic family and systemic psychotherapy. She can be contacted at psychlarityconsultancy@gmail.com

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Thinking theory and talking ordinary

An interview with John Burnham

You are incorporating NVR in your practice, how have you done this?

Two parents, who were also social workers, were struggling with one of their teenage children, who was adopted. Therapy was something of a roller coaster and the parents were beginning to formulate his behaviour in rather pessimistic diagnostic terms. Fortunately, we shared a value of not giving up, or giving in. One session they began: *"We've found this article on something called NVR. We think it might be helpful"*. Tell me more! They spoke of 'raising parental presence', 'striking while the iron is cold', 'supporters', 'announcements', and 'sit-in'. Their renewed motivation became mutual. Over time, we worked through the 'steps' as they saw them, and learnt together. NVR had strong resonances with systemic approach, methods and techniques (Burnham, 1992). It both fitted with and extended my repertoire rather than requiring me to change direction altogether.

Which aspect of NVR first interested you?

How the 'practice mantras' catch the attention of families. I call this *"thinking theory and talking ordinary"*. Cecchin talks about 'creating a state of curiosity in the mind of the therapist' (1987, p. 407). I love practices that *create a state of curiosity in the mind of family members*. Creating this state of curiosity often leads family members to go beyond the immediate or instant practical value, discovering and embracing the concept or value that inspires the method or technique. Embracing the principle or value is more likely to trigger a second-order change, and families can generate and personalise or culturalise their own practices.

What do you think are the strengths and challenges of using NVR across different countries and cultures?

When NVR is securely situated within a systemic approach (and not only seen as a set of particular techniques) then it has more chance of flourishing across countries and cultures. Although the word 'violence' is in the title, what is 'absent but implicit' is the promotion of love, kindness and peace, which I think is an international, transcultural aspiration. Culturalising NVR and engaging with local language or metaphors is an exciting challenge.

How do you see NVR sitting alongside systemic family therapy thinking?

NVR uses many systemic favourites: Batesonian concepts around escalatory relationships (Bateson, 1972); 'internalised other interviewing' (Burnham, 2000); and 'solution focus' (De Shazer, 1985). Simultaneously, NVR and associated mantras are becoming a regular part of systemic practice conversations. Different directions occur: NVR could find a home within family therapy; go it alone; or they could create a mutual influence through relational reflexivity is another?

How do you see your use of NVR developing in the future?

Having an established place in my practice. A senior NVR practitioner/trainer said: *"That's the way I do it, now go and do it your way"*. I sometimes use NVR reverentially and rigorously with clients. Sometimes, I am more irreverent, creative and imaginative. See Burnham, Brain and Juanella in this issue.

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John Burnham is a consultant family and systemic psychotherapist at Irwin Eating Disorder Unit at Parkview Clinic, Birmingham. He co-runs the Multi-family Therapy programme with Beki Brain, and is interested in generating resources for multi-family therapy programmes.

Questions were posed by Joanne Buchmüller and Rav Khela.

One perspective on NVR

Karl Tomm

I first engaged with NVR when Haim Omer invited me to attend the 5th International NVR Conference in May 2018. I happened to be teaching at the Barcai Institute in Tel Aviv at the time and Saviona Cramer put us in touch. The NVR approach immediately appealed to me because it offered a cluster of respectful therapeutic initiatives for responding to situations where a disruptive child, adolescent, or adult child adamantly refused to cooperate. The orientation to focus on influencing the ecology of that child, rather than trying to influence the child directly, resonated with my systemic focus on interpersonal patterns of interaction (Tomm *et al.*, 2014). I later attended a workshop in Calgary by Peter Jakob and Dan Dulberger, and subsequently collaborated with Dan in applying NVR methods at the Calgary Family Therapy Centre over two years.

What is so refreshing about NVR are the practical strategies that Haim and colleagues developed in applying the wisdom of Mahatma Gandhi and Martin Luther King in addressing injustices collectively, but at the family and/or local community level. Also appealing in NVR is the emphasis on maintaining a calm and caring parental 'presence' whilst challenging problematic behaviours. Most family therapists recognise how disruptive behaviours tend to recur and escalate when significant others in the child's social network inadvertently provoke the behaviour or accommodate to it. An emergent coupling evolves between disruptiveness and the reactions to it. For instance, parental efforts to impose authoritarian control over the child's misbehaviour often trigger escalation, aggravating the disruption, which then 'calls for' more control and so on. Similarly, parental 'caving in' to or accommodating to the disruptiveness unwittingly reinforces it. In contrast, when the responses of parents change to privilege respectful and authoritative 'presence' (both physical and psychological availability), the child's behaviour tends to change in reciprocity. However, enormous support is often

required for parents to make this shift. This is where NVR draws so effectively on the wisdom of collective resistance by mobilising the parents' social network to foster transparency and solidarity.

My concern about NVR revolves around how it is implemented by professionals. The 'new authority' in a therapeutic system can drift towards becoming instructive and come across as authoritarian. I realise this is not intended but when one's passion for the approach eclipses the humility required to notice and listen to actual effects, imposition may occur. Alternatively, when NVR methods are introduced invitationally and are accompanied by compassionate curiosity about actual effects, the therapeutic process unfolds more collaboratively. I intend to continue using NVR initiatives from time to time in my systemic work with families and hope to learn further as I gain more experience with this generative new development in our field.

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Karl is a professor of psychiatry at the University of Calgary, where he founded the family therapy programme in 1973.

An interview with Haim Omer

You have recently written a new NVR guide for parents, could you say a little about why you wrote this now?

My new book, *Courageous Parents: Opposing Bad Influences, Impulses, and Trends* (2020), synthetises 25 years of my work with parents in simple and accessible language, so that parents may use it on their own and counsellors may use it as an adjunct with the parents they treat and coach. NVR has changed and branched out significantly since its origins, so I felt putting it all together was indicated, especially as the concept of the parents' anchoring function created a new theoretical and practical umbrella, making new sense of the things we had been doing. This concept is the basis of the whole book. The anchoring function is our answer to the double challenge facing parents in our generation, a challenge that to my mind has no equal in human history. Why?

In the past, adults represented knowledge and wisdom. Today that role has been assumed by the internet, and children are more connected and up to date than their parents.

Children have never before faced the deluge of temptations they do today. They are flooded with a tsunami of seductions and stimulations resulting from an affluent society, harmful trends, and addictive substances. The temptations are all the more alluring because their dissemination through advertising means they reach children at all hours of the day and night, not only through television but also through the smartphones to which children's eyes and ears are glued at every moment.

Just when our children are so dangerously flooded, there has been a drastic drop in parental authority and influence, due to far-reaching changes in social structure and educational values. Parents are weaker, primarily because they are lonelier. The shrinking of the extended family is a worldwide phenomenon. Parents are much less supported by grandparents, aunts and uncles, and other community members than in the past. The rate of divorce and the increase in single parent families have risen sharply. Today's small family is increasingly isolated in its own apartment.

Parents are also weaker because the means of authority they once wielded have been taken away from them. It is a positive process in its own right – after all, corporal punishment and achieving obedience through force are negative phenomena whose eradication we are justifiably proud of. However, it is doubtful parents have received means to fill the vacuum left in their wake. To the contrary, there is a feeling that not only are other measures absent, but when parents turn to the ways of the past they are astonished to discover everybody is up in arms against them.

Added to this is a sweeping cause of weakness: the internet. In the past, adults represented knowledge and wisdom. Today that role has been assumed by the internet, and children are more connected and up to date than their parents. Today, the source of "wisdom" is literally in the child's hands. Sometimes parents are tempted to yank their children's devices out of their hands, as a punishment among other reasons. They say, *"It's the only punishment that works"*. The problem is that this does not work and parents are unable to sustain it.

That is the situation that led me to write *Courageous Parents*. Our answer to the crisis in child rearing is: helping parents to restore their anchoring function. Every principle, technique and tip in the book expresses this idea: getting parents to serve as anchors against the mighty currents that affect children and families.

How has your NVR practice changed since the publication of your book "Parental Presence" in 1999?

The saga of NVR began with a problem with our initial central concept, that of *parental presence*. Some parents understood parental presence as meaning they should achieve full control over the child. This interpretation might lead some parents to go home and set up barricades, conveying inappropriately dominant messages. Thus understood, parental presence could lead to escalation. NVR provided an answer to this challenge.

NVR is probably the only model of social struggle that is carried out by and through the personal, emotional and moral presence of the activists. The struggle is not conducted by throwing stones, arrows and bullets from a distance, but by the determined presence of the activists, which conveys the message *"We are here! We stay here! We won't budge!"* NVR is also the only kind of resistance in which the activists are rigorously trained to avoid all acts of violence, as well as all provocations, denigrations and offensive acts that might lead to escalation.

Leaders like Gandhi and Luther King were not only inspiring political figures but also master strategists. They created a detailed lore about how to translate those principles into day-to-day practice. They developed cadres of trainers and field leaders who helped transform a moral political philosophy into a highly-effective resistance machine. Fortunately, the richness of NVR's principles, strategies and tactics found their ideal historian and codifier in the figure of Gene Sharp. His classic book *The Politics of Non-Violent Action* (1973) is like a Talmud of NVR, providing guidelines for every imaginable situation.

With the help of a few dedicated students, each intervention, strategic principle or tactical measure described in Sharp's book was examined in detail for its potential to the field of parenting. The marriage between this work and our previous experience with parental presence led to the publication of *Non-Violent Resistance: A New Approach to Violent and Self-Destructive Children* (Omer, 2004). This book was not the end, but the beginning of a process. Some of the most important developments in NVR came in its wake. For example:

a. The theory and practice of *parental vigilant care* turned NVR into a major approach in preventing risk behaviours by children and adolescents (Omer, 2017). We showed the model to be effective in reducing patterns such as internet addiction, dangerous teen driving, anti-social acts and health damaging behaviours. In parallel, our colleagues in the UK developed variations of NVR designed to help parents cope with particularly extreme situations. Elisabeth Heismann *et al.* (2019) and Peter Jakob (2018) adapted NVR to kids involved with gangs and at risk of sexual exploitation and to multi-stressed families.

Teaching is one of the professions with the highest burnout rate

b. Anxiety and other disorders of accommodation – In close collaboration with Eli Lebowitz, we developed the first systematic adaptation of NVR to children with an internalising rather than externalising disorder: the SPACE programme (*Supportive Parenting for Anxious Childhood Emotions* – Lebowitz & Omer, 2013). The rationale for applying an NVR-based approach to those families was due to the parents' loss of their personal space (hence the acronym) on account of their child's anxiety disorder. The loss of the parents' space is illustrated by the fact that many of them lose their ability to have a room that is really their own, to control their own time, to meet with friends, to go out as a couple or manage the house as they see fit. SPACE includes a set of practical tools to help parents identify and reduce the various forms of accommodation they provide, while positively coping with the child's harsh responses. Applications of NVR for internalising disorders are rapidly expanding, for instance: obsessive-compulsive disorder, autism spectrum disorders, avoidant/restrictive food intake disorder, and adult entrenched dependence, which refers to "adult-children" who do not study, work or function, remaining mostly completely dependent on their parents.

Experiences of shame that come with messages of rejection and ostracism can be profoundly damaging

c. Schools – School interest in NVR is rapidly growing. The reason is probably that teaching was amongst the roles most affected by the critique against traditional authority. Teaching is one of the professions with the highest burnout rate. We believe teachers' growing helplessness in the face of phenomena like violence, chaos and widespread parental hostility are among the chief attrition factors. NVR is possibly the only approach that views teachers not only as service providers, but also as clients in themselves. We believe that unless the teachers fare better, the children have no chance of doing so. Therefore, we can say to any demoralised teacher: *"The goal of NVR is to strengthen you by making you less isolated, more supported and with more legitimate and effective reactions at your disposal. You and the children are equally important to us!"* Teachers often feel motivated by such an approach.

We developed systematic ways of increasing teacher presence in the class and courtyard. Teachers learned that developing self-control not only increased their ability to elicit respect but also helped them to avoid the abrasive effects of emotional outbursts. Many teachers made the discovery that self-control was a source of strength

Various avenues were opened for endowing teachers with a support network, sometimes in the very contexts in which they previously experienced criticism and hostility. Thus, a crash course on *teacher-parent diplomacy* helped teachers improve their relationship even with highly-problematic parents. Teachers learned to react as teams and use teacher support groups not only to feel better, but also for acting more effectively. The move from "I" to "We" turned out to be crucial for changing the experience of isolation and vulnerability that had made the lives of many teachers impossible. School principals found out that NVR rescued not only the teachers, but also themselves from their sense of isolation and of fighting simultaneously on different fronts. The children's support could also be mobilised, as it became clear that they were part of the community of resistance against bullies and vandals.

Information on these and many other special fields of implementation, such as with foster parents, children with attention deficit hyperactivity disorder, suicide threats, police work, and applications to a whole community can be found on the website www.haimomer-nvr.com.

There is an idea that NVR shames young people and children and that this is harmful. What do you think about this idea?

The experience of shame is always unpleasant but not always harmful. On the contrary, it plays a critical role in developing a child's sense of belonging and moral development. The difference between a harmful and constructive experience of shame has to do with the broader interpersonal and emotional context in which the shame is experienced. Experiences of shame that come with messages of rejection and ostracism can be profoundly damaging. Shaming punishments that include marginalisation, humiliation or derogatory expressions can be traumatic. It is very different when the child experiences shame but in a context that conveys support and belonging.

In our programme for coping with children's violence we make a special use of "public opinion," but the "public" in question comprises a group that has a positive attitude towards the child. To do this, we help parents and teachers gather a group of supporters made up of members of the

extended family, friends, school faculty and other meaningful figures (such as a sports coach or youth counsellor). When the child commits a violent act (such as hitting his or her sister), the members of the group receive a detailed report. Then one or two members of the group contact the child and say: *"I know you hit your sister yesterday. You know I care about you. I think highly of you and I am sure you can get this under control! I am also willing to help you avoid getting into such situations. But hitting your sister is violence and it must stop"*. This address includes three positive messages: a message of love and connection, a message of trust and appreciation, and a message of willingness to help. This creates a positive context, which helps the child contain the experience of shame. The combination of messages of appreciation, belonging and support, along with an honest and direct reference to the problem behaviour, strengthen the child's ability to tolerate the shame. Such experiences are critical for proper development.

What would you say to systemic therapists or practitioners who are curious about how NVR could fit into their systemic practice?

NVR is a systemic approach. Even though we work with the parents, the concepts, understandings and interventions are clearly systemic. Our mentors, besides Mahatma Gandhi and Martin Luther King, are systemic masters such as Gregory Bateson, Salvador Minuchin, Steve de Shazer, Milton Erickson and Chloe Madanes. NVR can be applied in different ways. Experienced systemic workers may incorporate some of its principles and techniques into their own practice, thus creating their own integrative style of family therapy. Perhaps a therapist who is completely new to these ideas should begin by undergoing a systematic training in NVR and getting some supervision. However, I think some of our ideas can be implemented by any experienced therapist. For instance: how to convince parents to mobilise a support group; how to orient the supporters; how to improve self-control and reduce escalation by simple ideas such as the principle of delay (*"Strike the iron while it is… cold!"*), or relinquishing the 'illusion of control' (*"You can't control the child, but only yourselves!"*). Perhaps the most imminently applicable idea in our whole repertoire is that of presence. Helping parents to become more present in the lives of their children is something each and every systemic therapist can do. We have gone beyond this immediate piece of advice, by detailing the systematic approach of *vigilant care*, which we have shown to be a good way of reducing a wide variety of environmental risks. Each and every therapist can start utilising and

disseminating the ideas of presence and vigilant care tomorrow, even without any special training. Actually, every parent can profit from those ideas. I tried to show parents and therapists how to do this in my book *Courageous Parents*. Therapists who are parents themselves can profit twice for the same price.

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Haim Omer (www.haimomer-nvr.com) is a professor emeritus at the School of Psychological Sciences at Tel-Aviv University. He is the author of 11 books (translated into 10 languages) and more than 100 academic articles. His approach, known as 'non-violent resistance' or 'the new authority', is a major influence in family guidance, school interventions and the prevention of risk behaviours by children and adolescents. He has published many studies on the method and its applications with parents of children with impulsive and aggressive behaviours, anxiety disorders, social withdrawal, juvenile delinquency, teen-drivers, computer misuse, violence against siblings, child-to-parent violence and school refusal. There have been five international conferences devoted to the approach (London, Antwerp, Munich, Malmo and Tel-Aviv), as well as dozens of local conferences in more than 20 countries.

Questions were posed by Rav Khela and Joanne Buchmüller.

Interview with Dan Dulberger

Where is NVR taking you?

Before relating to my specific journey, here is a thought about my experience of NVR as a vehicle of social innovation. There is NVR practice in the stricter professional sense, and there is the way in which, over the past 25 years, the practice has been helpful for exposing critical dead-ends in social discourses: points where master narratives become dysfunctional, toxic, or lag behind sociopolitical and technological realities.

Apparently, it is an unintended consequence. NVR's origins – like its originator Haim Omer – are humble and pragmatic. Whatever the applicative context, the mission is to empower caregivers facing the disruption of care by the cared-for. In this process, however, greater social issues are identified and dealt with than intended. For example – NVR's original quest was to help parents of children with disruptive behaviours restore a sense of agency to their broken role. That quest, however, indicated that part of the problems parents face originates not in their intrinsic shortcomings, nor in their relational patterns, nor in the many products of the parent-blaming industry, but in the systemic failure of a social discourse called "old authority" to bridge between the family's need to maintain hierarchy, and its growing need to respect children's autonomy. NVR helped parents re-invent themselves by offering a new and more workable social discourse called 'new-authority'.

I would describe it as a *therapeutic approach that aims to change harmful power differentials through caring, communal resistance*

In a similar way, NVR work with helpless parents of adult children exposed "independence" as a defunct social discourse of adulthood and is prompting an exploration of "new autonomy" as a more functional alternative. There are more examples I could think of, related to prevailing social discourses of trauma and anxiety, which our NVR work leads us to question and seek alternatives to. Some would view this as a subversive side-effect of our practice. I see it as more central: non-escalating resistance helps question things.

More personally, NVR is taking me to interesting dialogues with the narrative, IPScope (interpersonal pattern scope), and the 'ecosystemic structural family therapy' approaches. It is taking me on a journey exploring non-emerging adulthood as a long-term, multi-systemic condition connecting numerous developmental points from youth at invisible risk, to transitional challenges between child and adult heath systems, to social withdrawal and elderly abuse. It is inspiring me to think of new applications related to neurodevelopmental diversity and adoptive parent communities. It leads me to think about how NVR can form part of an impossible-case practice, resisting adverse socially-constructed impossibility. It makes me reflect on NVR's need to anchor its own applicative expansion by deepening its theoretical foundations. Last, but probably most important, NVR is making me reflect on the critical role its communities have in maintaining the wellbeing of its practitioners. A community of NVR professionals that does not take a firm, non-escalating position against violence within its own domain, is an oxymoron.

How has NVR shaped your practice as a family therapist?

My development as a family therapist and my formation as an NVR practitioner very much shaped each other, first by dissonance, then by resonance. My initial – and naïve – perception of NVR was of a wonder-approach. I was impressed by the ability to achieve quick progress where previous attempts involving more "traditional" systemic or individual approaches failed. This would often create either/or gaps and friction with supervisors. With time, and learning, and co-therapy, NVR's boundaries, vulnerabilities, and contra-indications made themselves known, and the tension subsided. Over a few years I learned how to use NVR to simplify systemic work and its clinical complexities. At the same time, I learnt how systemic and narrative insights can help overcome the cognitive barriers to behavioural change, facing NVR's pragmatic goals.

NVR expanded my systemic practice in the following ways. As a unilateral, yet systemic practice, it allowed me to assist families that are suffering in their relations with members who refuse therapy. As a community-based intervention, NVR enriched my view of the family as embedded, for better or worse, in its wider socio-political context, and of the critical importance of addressing this context. As a methodology of caring struggle, NVR helped me acknowledge the essential links between unwellness and oppression, and between non-escalating struggle, empowerment, and healing.

What connections do you see between NVR and systemic therapy?

I think that NVR is defined by its practitioners, not all of whom are systemic therapists. NVR was born in an academic psychology department, where it is taught to this day by clinical psychologists. I am not sure to what extent "non-systemic therapists" who practice NVR would describe it as necessarily "systemic". One exception is of course Haim Omer, a clinical psychologist by education, who once commented that all therapy is systemic. I share this view, hence the question to me is not whether, but how is NVR systemic.

Going from 'whether' to 'how' may be less straight-forward than it seems. To me, *helplessness, presence, vigilant care, reconciliation, resistance,* and *anchoring* are all relational

concepts. As an NVR practitioner I represent NVR's problem, change process and outcome all in systemic terms. If I had to offer a tentative definition of NVR as systemic practice, I would describe it as a *therapeutic approach that aims to change harmful power differentials through caring, communal resistance.*

As much as I see NVR as a systemic practice, however, I think that this view still implies an unresolved tension. NVR is premised on coming to terms with our inability to change or control others. However, if all we commit to is self-change, in what way can I still view NVR as a systemic practice in the tentative definition I offered above? I wouldn't call it a full-blown paradox, since self-regulation does impact others. But there's still a twist here: NVR teaches us that to caringly impact others we need to shift our focus from them to ourselves and prepare to accept that our ability to care for them is bounded, and may result in total failure. Perhaps it can be said that NVR aims at systemic change by aiming away from it, never promising it, nor renouncing. It explores an interpersonal 'transitional space', where the answer to the question *"Who are we here to change – the caregiver or the cared-for?"* is *"both, probably"*.

Where does NVR fit with Canadian culture and wider cultural contexts?

My brief experience here as a newcomer has so far been exceptionally encouraging. NVR's blend of non-escalation and firm determination seems to resonate well with Canada's cultural climate, especially in times like these. Canada today is a growing part of a rapidly diminishing global space where 'diversity', 'inclusion', 'fairness', 'social justice', 'equity', 'civility' and 'immigration' still thrive as social values, not just speeches. I am not starry-eyed. There are many social challenges and legacies here and Canadians have as many reasons for concern as the rest of the world.

NVR teaches us that to caringly impact others we need to shift our focus from them to ourselves and prepare to accept that our ability to care for them is bounded

But, as of now, I think that the perceived urgency of protecting these values is driving an immense curiosity to learn more about NVR among professionals and parents alike. During 2019-2020 I had the pleasure of supervising family therapy interns at the Calgary Family Therapy Center, and in this winter of 2021 I will be delivering NVR training to practicum students at the University of Calgary's Faculty of Social Work. Almost every week I receive some enquiry about NVR from within Canada or from the USA. In April 2021, Peter Jakob and I are invited to Philadelphia to introduce NVR to interested family therapists. All in all, I feel NVR is poised to spread its wings in North America in 2021.

Dan Dulberger (right), together with Dan Wulff (left) and Sally St. George (middle) of the University of Calgary, who helped to introduce NVR into Canada. Photo: Kloie Picot.

Where do you see NVR in five to ten years' time?

In these uncertain times, my only working assumption is that the next five to ten years will radically change what most of us deem "normal" or "impossible". I see an important role in this future for NVR, both as a social approach to therapeutic change and as a therapeutic approach to social change. I see it being taught in police academies. I see it becoming part of the training curriculum of any profession that involves caring, educating, or governing. I see it being studied by political activists, as part of the larger body of knowledge related to non-violent resistance. I see it coming back the full circle, from the micro-political arena back into the macro, bringing with it many new lessons on the psychology and therapeutics of the non-escalating struggle. I see an ever-expanding range of new NVR applications, including NVR-informed social methodologies for consolidating consumer power, standing up against bureaucracy and the mechanisation and commoditisation of human relationships. At the same time, I see more work into NVR's theoretical and philosophical foundations. I see all this happening not in spite of the radical change we are facing, but because of the opportunities it creates.

Dan Dulberger is a family and marital therapist, an NVR practitioner and trainer and an author. He is based in Calgary, Alberta.

Questions were posed by Joanne Buchmüller and Rav Khela.

Non-violent resistance-based interventions in residential care with teenage refugees: *Finding new ways*

Kerstin Thys and Annelies Huybrechts

In this article we describe how non-violent resistance has inspired us to find new and creative ways to improve the guidance of unaccompanied teenage refugees in residential settings.

Many children have left their countries of origin and have come to Europe without the guidance and protection of their parents. They have had to go through all kinds of extreme life experiences.

Being unfamiliar with the new culture and language, with legal procedures, with the health care and the educational system of the host country, these children – while often very resilient and talented – are among those with large unmet emotional needs. The diverse cultural and social backgrounds, and the complex and vulnerable situation of these children living together in a group leads to a challenging working environment.

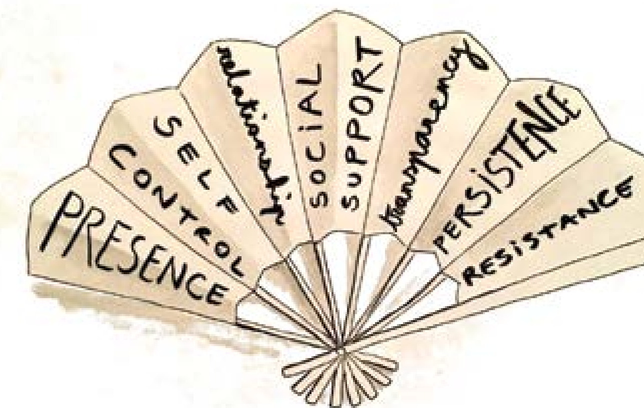
The image of a fan as a way to talk about 'vigilant care'

Explaining to the children what we do, why and how we want to deal with concerns and conflicts is not easy. It is already a challenge to discuss this with people who share the same language and cultural background. It is very important for us, for the children and for their family members that we can talk about these things in a very transparent way so that we can understand and support each other and exchange ideas in collaboration.

The image of a fan was designed for this purpose and has given us words to explain our ways of working based on the concept of 'new authority' and 'non-violent resistance'.

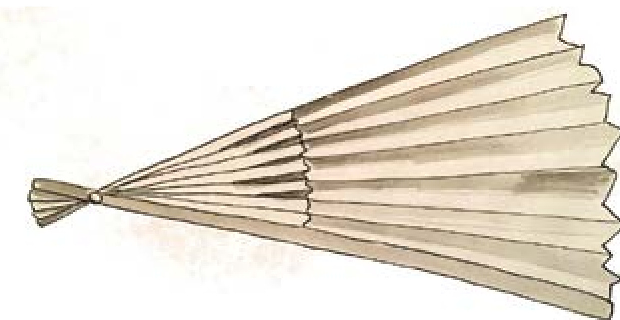
The fan illustrates 'vigilant care' (Omer, 2015). When there are no concerns about the development of the child, the fan can be kept in your pocket. To be present in the child's life, building self-control, investing in the relationship with the child, asking for social support, being transparent and focusing on the process are leading ideas in the way we, as adults, work together to care for the children.

When concerns are rising, or if the development of the child is endangered, we can pick the fan and open it up in order to provide more oxygen, to feel less helpless and more empowered.



In this stage the caregivers will be more present, pay more attention to keeping self-control, need more social support from their network, have to find constructive narratives through which they can stay transparent and, when they find themselves in dark moments, they will focus on the process of change. At the same time, during harsh times and in the middle of conflicts, it can be hard to keep the concepts in mind and to act according to them. Images can be strong and helpful to guide us in the direction of a destination we want to reach.

The conversations about vigilant care with the image of a fan have also given us opportunities to expand the child's capacity to imagine that contact between staff and his or her parents would be beneficial (Beckers & Jakob,



Illustrations by Karolin Wuyts – Karolinwuyts@hotmail.com

2019). Many children protect their privacy and family secrets and decline direct contact between the professionals and their parents, who live far away. We discuss and prepare together how we will make contact, what we will discuss and not discuss and the importance of presenting ourselves to their parents. This way we enlarge the possibility that they allow us and entrust us to speak with their family members.

"Dear father of Mirza (pseudonym),

I want to present myself and my colleagues to you.

Your son is going to translate my words to you.

I work in the residential setting where your son is currently living.

He can live here, he can go to school, he can get medical treatment if it is necessary, he can use his phone, he has a lawyer, he can practice his religion and can have halal meals if he wants to.

We want to be there for him, on good and on bad days.

We want to understand him, to care for and support him in his development and to guide and give him boundaries.

From our experience we know that this period of adolescence in diaspora is a very complicated stage in life with loads of worries.

We from our side will stay as calm and stable as possible in addressing difficult days.

We work together with him, with you, with our team, with school and with other volunteers and professionals.

We do not accept aggressive or self-destructive behaviour in our organisation and if it occurs, we will resist it. In such times we will follow your child closely and look for more cooperation with the family.

We don't give up. Instead we'll work harder as we head into a better future.

When our concerns become less urgent, we will again grant more freedom and personal space.

This way of working together can be illustrated with a fan: a fan that symbolises the values of presence, self-control, connection with your child, a better future and cooperation in transparency. We can keep the fan in our pocket and we can hold it in our hand and open it up to get fresh air and strength.

If you would like to discuss and exchange ideas again, we can speak to each other at another time. Today, I wanted to introduce myself and my team to you.

Bye for now, and Mirza, thanks for translating and for enabling this contact between us and your parents to take place."

Increasing predictability and recognising undocumented suffering in the announcement

Most of the children experienced extremely negative life conditions and were – and still are – confronted with a lot of insecurity, unpredictability and helplessness. When an announcement or sit-in or another one-sided action occurs, teenagers can be surprised or even puzzled because they didn't expect to see these ways and expressions of resistance. It is also through this feeling that the action can be remembered as a meaningful and special moment in a process of change (Omer, 2018).

With young refugees, however, this way of being surprised can have the opposite of the expected effect. It can lead to strong feelings of danger, fear or panic not coinciding with the aim of the undertaken action. When intervening with one-sided action, we therefore want to keep their new world safe and predictable by 'announcing the announcement'. A short notice just a few minutes before this intervention can prevent a traumatic response. As we announce the announcement, we also go through the agenda of the day to connect this intervention with the course of a normal day. This trauma-sensitive-adjusted announcement preludes the start of a process of change.

"Hi Mirza,

Good to see you here in your room. Hope you're fine. Please stay here for a while because in a few minutes we will briefly join you to tell you something. Afterwards we will have dinner together and start the evening activity."

In the announcement we also pay particular attention to the recognition of the often-undocumented suffering in the past and the need to belong to the group:

"Mirza,

We listened to your story with sadness and anger and we feel so sorry for the injustice and suffering that crossed your path. You have seen many sides of the world. You saw how evil the world can be. It defeats our human understanding. What has happened was wrong and not your fault.

We hope you feel welcomed and part of this new group. You are one of us.

You belong to this group.

You have enriched the group with your talent for singing and poetry.

Together we stand for a world without violence.

We will therefore insist on a safe group and will no longer accept that you threaten other people with knives, carry them with you or keep them in your room.

We believe in your power and your capacity to overcome your pain and fear with our support."

Multicultural meetings with elders as a way to broaden networks and to facilitate social support

Starting afresh in Europe often leads to a predominantly homogeneous network consisting of peers they have met in the refugee camps. The presence of parents or other meaningful adults in refugees' lives is generally low. For the professionals it is not easy to build a cooperative relationship with the family members. This fact has led our team to involve elders from different cultural backgrounds within our work place. We invited them to meetings in order to hear the adult voices and discuss complex questions together. They supported us in many ways, for example with difficult group dynamics like understanding and handling ethnic tensions.

Sit-in as a way to build a non-violent group climate

After an incident, we come together as one and as an act of resistance. We sit down together in a circle and talk about our values and ethics in dealing with conflicts, and we look for solutions so that it will not happen again.

We have learned to use a diplomatic and polyphonic way of talking. Being sensitive to feelings of shame (Weinblatt, 2018), to the need to belong (Jakob, 2011) and to the fear of being expelled from the group, is very crucial to the way we speak to and address the group:

"Dear youngster,

We are here together today because ethnic tensions divided us.

As we told you this morning, we also welcome mister Zia and mister Farhad.

Zia and Farhad are good friends with different ethnic backgrounds. They have supported our organisation already for a long time and came today to help us with the process of overcoming ethnic tensions.

With our presence we tell each other that we care and stand for a safe place, which is good to live and to work in.

Some people might think this coming together cannot make a difference. Others might think it can make a difference. Some of us are still angry. Others could be hurt or afraid. Some of us don't see the reason why we deal with it in such a serious way. Some of us have other feelings or ideas or feel mixed up…

We want to look for solutions and we ask for ideas and support from everyone so we can move on together into a safe future…"

Summary

Given the complex situations and the unmet needs of unaccompanied minor refugees, feelings of helplessness and insecurity are commonly experienced by the children, the staff and the children's parents. These feelings can easily lead to the escalation of processes. NVR has provided us with multiple ideas and ways to react and deal with difficult situations in a non-violent spirit and attitude, this way also rekindling the caring dialogue between the children and caregivers.

The fan as an image of vigilant care gave us a joint language with which to explain our values and the way we work. By enlarging our support network with elders from different cultural backgrounds our blind spots became clear and filled with rich ideas. This cooperation strengthened us all and enhanced feelings of connection between cultures and generations. The announcement with particular attention to predictability and to the recognition of undocumented suffering, and the sit-in with a diplomatic and polyphonic use of language created hopeful ways forward.

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Kerstin Thys is a psychologist and systemic therapist working in Minor-Ndako and de Vliegeraar and a freelance trainer for the Interactie-Academie.

Annelies Huybrechts is a psychologist and systemic therapist working in a private practice and a freelance trainer for the Interactie-Academie.

Non-violent resistance-based interventions in residential care with teenage refugees: Finding new ways

Regulating the emotion of shame: *A key factor in helping family members reconnect*

Uri Weinblatt

Parents and children who are involved in intense conflicts often experience shame. Parents feel ashamed of their parenting, their child's behaviour, needing help, and their helplessness. The child feels ashamed of his or her failures, often social and academic in nature, of receiving the negative attention, of his or her weak parents, and of his or her own behaviours.

When we fail, make mistakes or lose, we experience the emotion of shame, a sense of inferiority and a drop in self-worth. When shame is regulated, this experience, while certainly not pleasant, does not affect our perception of who we are. We say to ourselves, *"sometimes you win, sometimes you lose,"* and see the situation as temporary and rectifiable. However, family members who find it difficult to regulate their shame experience failure much more intensely, which leads to attacking and withdrawal behaviours respectively. The therapist's role in these circumstances is to coach parents and their children to cope with such experiences effectively rather than hastily attack or retreat.

Involving supporters as means of regulating shame

The level of shame determines the willingness to open up to others, consult them, get help from them, talk and communicate, care and to be cared for; in short: to connect. When the level of shame is regulated, receiving help is experienced not as humiliation but as support; however, as the level of shame rises, the ability to receive such help is diminished.

In NVR we help families regulate shame by creatively involving the public in their lives (Weinblatt, 2019). Interventions cultivating the power of supporters are manifested in two ways: (a) when supporters enable family members to "have a voice" concerning their pain and suffering, (b) when supporters communicate through empathic and non-judgmental ways to both parent and child. In both situations we aim to cultivate respectful rather than shaming conversations.

For many families such public involvement is not an easy task. The decision within families of what may become public and what should remain private is constantly negotiated. It is usually shame that constructs and signifies the boundary between what is private and what should remain public. As shame grows, private life becomes more dominant, keeping relationships with other people at distance. As this dynamic intensifies, the attitudes of others become threatening and dangerous. This process breeds more alienation, isolation and shame, which in turn present more obstacles for people to utilise their support system in helpful ways. In NVR therapy we challenge this process through interventions which renegotiate the boundary between the private and the public and ultimately lead to improvements in the regulation of shame.

Danger: Conversation!

Helping parents and children to have fruitful, less shaming interactions with their social environment is crucial. Yet ultimately, we want family members to be able to have positive conversations that lead to connections among themselves.

Since most kids who experience unregulated shame don't like to talk about themselves, any attempt to involve them in a conversation can lead to frustration, a sense of helplessness, and despair:

Parents: *"We see that something is bothering her, but she won't let anyone into her world".*
Therapist: *"You have obviously tried to talk to her. How?"*
Parents: *"We tried everything! She just won't talk to us".*

To fully understand why talking is so difficult for kids whose shame is not regulated, we must first acknowledge that, for them, a conversation spells danger. Yes, conversation is not only difficult, but can also be dangerous. Why so? Because a conversation can abruptly trigger shame – especially, but not exclusively, when the issue is sensitive.

Why shame? First, conversations induce emotions – they can make kids feel sad, angry or scared. Many children, especially boys, feel very ashamed only because they are experiencing such emotions. They feel exposed, susceptive and vulnerable, such that self-protection becomes their most urgent priority. Second, many conversations remind kids of their failures and of falling short of others' and their own expectations. These dynamics, in turn, give them the feeling that they are somehow flawed and worthless. The result is utter misery.

Parents: *"We want to talk to you about what's going on at school".*
William (12): *"All right".*
Parents: *"Your grades are low. How do you think you can improve?"*
William: *"That's enough! Leave me alone! I don't want to talk about it!"*

Failures are a shameful thing. When parents want to talk to their son about a failure – be it something he did wrong, low grades, unacceptable behaviour towards others – in the boy's mind's eye, the conversation quickly moves away from its initial topic and turns into the challenge of working through an acute experience of shame. Insofar as shame impairs his ability to cooperate within the conversation, the focus of the latter will often shift to his failure to interact respectfully.

Children and adolescents do not know and cannot articulate how their shame is impacting the conversation. They can't, for example, say: *"At the moment I'm careful not to talk too much, because I fear I may become excessively vulnerable, and this might later make me angry at myself or you".* However, they do unconsciously grasp the bottom line: talking is dangerous, and costs could be high. Accordingly, many will forgo conversations altogether, and try to deal with their problems on their own.

So, should we try to have a conversation?

Parents are often faced with the dilemma of whether to start a conversation even though it might hit the raw nerve and evoke shame, or opt out, thereby eliminating that risk but depriving the child of much needed help that could prompt him or her to navigate out of an emotional impasse. A good decision in this regard depends on the level of shame the child or adolescent can tolerate, and is therefore contingent on accurately assessing this capacity.

Conversations, with all the snags and hurdles inherent to them, are still the most direct path to regulating shame (Weinblatt, 2018). However uncomfortable children and adolescents may feel talking, and in spite of their eagerness to avoid dialogue at any cost, conversations are still the most potent means to alleviate shame-driven pain, the vulnerability that always lurks around the corner, waiting to burst, hurt, paralyse and silence them.

For some kids, any conversation, even a short exchange, can be an ordeal and therefore requires preparation. This step allows them to maintain their dignity and gain a degree of control over the conversation, and it also mitigates their vulnerability. William's parents, for one, would have improved their chances for a constructive discussion of their son's grades if they had prepared him accordingly:

> *"We know you are really not in the mood for talking about school, but we need to talk about it, and we promise to keep it short".*

Young people can be eased into a conversation through an "introduction", to help them feel respected and to soften words they might otherwise perceive as critical or accusatory.

Communicating without shaming

We are all more critical than we think we are.

Kids absorb quite a bit of criticism day in day out, due to adults' unceasing efforts to help, educate and improve them. The more mistakes children and adolescents make (being rude, silent, dirty, inconsiderate, or playing all day on the computer etc.), the more haranguing and lecturing they endure. Parental language can be highly aggravating, an effect that parents are quite unaware of. In all innocence, they believe that the conversation is centered around facts, but their son perceives it as an all-out attack. The upshot is that both sides are infuriated and move apart.

Parents: *"You are always annoying your brother. You've never been nice to him – you just bully and insult him".*
Aiden (15): *"I'm tired of you pestering me!"* [storms out of the room]
Parents (to the therapist): *"Do you see how he behaves? He refuses to communicate!"*
Therapist: *"Maybe you were a bit overly critical in the language you used..."*
Parents: *"We were just stating facts; what's really going on at home..."*

When we feel hurt or powerless, we tend to use absolutes, such as "always," "never," or "all the time". Although, in the short term, such phraseology can empower us, it hurts young people, who are likely to respond with emphatically accusatory words of their own:

> *"You're always favouring my brother! You never listen to me. You don't love me! You're angry all the time, and nothing else!"*

In order to communicate effectively, parents need to reduce shaming messages, most notably criticism and blame. One way to develop a better awareness of verbal shaming is to identify and avoid terms that are commonly used in accusatory speech acts, such as "you," "always," "all the time," or "never". To the wary parent, resorting to such words signals that she likely feels hurt or helpless, and prompts her to change her tone:

> *"Right now, we feel hurt, but we don't want to hurt you back. We are very concerned about your relationship with your brother and would like to talk about it."*

Such a message incorporates an invitation. The parents focus on themselves and their feelings, and this may elicit a similar response:

> *"Well if you want the truth, then I'll tell you: I'm angry with you too!"*

Such an utterance may strike one as defiant, but in fact it is an attempt to accede to the parents' overture to communicate. From this point on, the parents' path to developing the much-needed conversation becomes less thorny:

> *"We are happy that you are sharing your feelings with us. What are you upset about?"*

Summary

Connecting regulates shame and kids have the need to connect – this is paradoxically the reason so many of them spend all their time in front of the screen. This kind of connection, however, comes at a very high price. A strong and stable sense of self is rooted in genuine and healthy connections, to others and to oneself. Such connections foster vitality, motivation to work, emotional resilience, and compassion toward oneself, even in the face of failure.

Conversations that are "shame sensitive" are inherently motivational, making kids **want** to cope with life challenges. Put differently, such a motivation arises not from lectures, confrontations, or imposition of boundaries, but from an affable yet powerful process of regulating the emotions that create inhibitions and ultimately lead to an impasse. For young people, regulating their shame fosters connection, not only with others, but also with themselves, their needs and true desires – which are both a prerequisite and preparation for the next step towards healthy development.

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Uri Weinblatt is a clinical psychologist and head of the Systemic Mirroring Family Therapy Practice in Israel. He is a renowned specialist in parent training and the treatment of children and adolescents with behavioural problems, and is frequently invited to give workshops and lectures in leading family therapy centres in Europe. His book, *Shame Regulation for Families: A Systemic Mirroring Approach*, was published in 2018 by Springer.

Highly dependent adult children ('failure to launch')

Eli R Lebowitz

Gradually transitioning from dependence on caregivers to independent functioning is a long-term process that begins early in life and continues throughout development. Infants begin life entirely dependent on their caregivers for everything from their very survival needs such as shelter, nourishment and protection from threats, to their emotional needs such as emotional regulation and soothing. As children grow and mature, they become increasingly capable of tending to their own needs and gradually take on more and more responsibility for filling them. Cultures differ widely in caregiving style and in normative expectations for individuals of different ages, yet the process of gradual maturation and the increased expectation for functional and emotional autonomy transcend culture and are present across human life.

By the time offspring are physically mature, generally by late adolescence or early adulthood, most are able to care for themselves and begin to experience life as independently-functioning adults. Separation from caregivers at this point is generally both acceptable and desirable (Arnett, 2000; Hendry & Kloep, 2010). Though cohabitation with parents can continue for a variety of reasons, adult children will generally spend much of their time outside the presence of caregivers, and many will have shifted to living away from parents either completely or for much of the time. Adult children are also usually expected to be increasingly financially self-sufficient. This can include being gainfully employed or investing in future employment through higher education or training. Adult children are also usually independent in their social functioning, seeking out and maintaining interpersonal relationships including acquaintances, friends, and intimate bonds.

For some significant proportion of individuals, the normative process of differentiation from parents and increased autonomy appears to stall. In some cases, the adult child never achieves functional independence from caregivers while in other cases the process becomes arrested or reversed. In such cases, the adult child continues to reside with parents or at their expense, is not engaged in productive endeavours in either the occupational or educational domains and relies heavily on parents for the fulfillment of most needs. Social life is also often limited, sometimes to the point of complete self-isolation from the outside world.

This phenomenon, which is sometimes termed 'failure to launch', poses bewildering challenges to all relevant stakeholders including parents, mental health providers and the adult children themselves (Lebowitz, 2016). Startlingly little is known about either the antecedents or the causes of so-called failure to launch. The prevalence of the phenomenon has yet to be systematically studied and there is a dearth of data on optimal intervention strategies for the problem. Indeed, in many cases treatment of any kind seems almost impossible. When parents of an adult child who is not functioning independently seek professional assistance from mental health care providers, the assumption is often that the adult child must attend therapy to learn how to overcome the challenges keeping them from living a fuller life. Yet in many cases such therapy is not feasible. The adult child may express little or no treatment motivation and may decline to attend even an initial evaluation or assessment. The unfortunate outcome is often that no treatment is provided, and time continues to pass, further entrenching an already highly intractable situation.

The sense of frustration and helplessness experienced by parents in this situation, along with the ongoing toll that parenting a highly dependent adult takes on the physical, emotional and financial health of parents contribute to the severe burden that failure to launch places on parents and families. This burden is exacerbated by the sense of shame and isolation engendered by the difficult family situation. Parents frequently cut themselves off from natural sources of support such as extended family, friends and the broader community, even actively hiding the reality of their lives from others and reducing their own social functioning. Likewise, the passage of time and growing discouragement and despair experienced by adult children who are unable to live independent lives, even as their peers progress through the natural steps toward autonomy, can contribute to severe mental health problems, further solidifying the lack of function in an ongoing cycle.

Parent-based treatment and non-violent resistance (NVR)

Parent-based treatment is most commonly applied in treating problems of children and adolescents and is rare in the context of adult children. Yet aspects of the failure-to-launch phenomenon suggest the applicability of parent-based treatment for this challenging situation. First, the common scenario in which the adult child expresses low motivation for treatment while parents exhibit a high degree of treatment motivation makes working with the motivated parents highly relevant; second, the dependence of the adult child on parents for most needs and the outsized role the parents play in the these adult children's lives can make the situation more akin to child or adolescent therapy than to typical adult therapy; third, the degree to which parents are usually accommodating the adult child's maladaptive symptoms provide practical targets for parent-based treatment; and fourth, the similarities between parent-based treatment for childhood and adolescent problems and intervention with the parents of adult children who remain highly dependent provide a natural translation of existing parent-based treatment protocols to this additional context.

NVR is a theoretical orientation and treatment approach that has been found to be effective for a number of childhood and adolescent problems. The method disavows the use of force and coercion in interpersonal processes and focuses on self-change rather than direct manipulation of the behaviour of others. Its processes emphasise the minimisation of escalation and conflict and rely heavily on social support and public opinion in place of direct force. These principles have been translated into parent-based treatment approaches in work led in large part by Haim Omer of Tel Aviv University (Omer, 2004)

The first implementation of NVR for parent-based treatment focused on work with parents of youth with severe externalising problems, including violence, aggression and destructive behaviours (Omer & Lebowitz, 2016). The treatment in this context focuses on providing parents with tools to resolutely resist the problematic youth behaviours, while minimising unhelpful escalation and recruiting support for the parents' struggle from outside the immediate nuclear family. NVR also provided part of the theoretical foundation for SPACE (supportive parenting for anxious childhood emotions), an entirely parent-based treatment approach for childhood and adolescent anxiety and obsessive-compulsive disorders (Lebowitz *et al.*, 2020). In SPACE, parents focus on reducing their own accommodations of the child's anxiety symptoms while maintaining a supportive attitude towards the genuine distress experienced by the child. By focusing treatment objectives entirely on reducing the parents' own well-intentioned but ultimately unhelpful accommodations, parent-child escalation is minimised as parents make no direct demands of the child nor attempt to use force in changing the child's behaviour.

Parent-based treatment, informed by the principles of NVR, provides a novel and potentially efficacious means of intervening in the context of failure to launch (Lebowitz *et al.*, 2012). Parents can identify the ways in which they are accommodating the lack of function in their adult child, and work to systematically reduce the accommodation to promote gradually better function. For example, when parents are contributing to the maintenance of social isolation by limiting the presence of others in their home due to the distress that social interactions cause their adult child, they can opt to open their home to guests and invite the guests to express support and care to the adult child. When parents accommodate by providing the adult child with internet access so that they do not experience the boredom that would naturally result from lack of any productive endeavours, they can make internet access contingent on some functional progress in the child. By maintaining the focus explicitly and exclusively on those things parents can directly control (e.g. inviting guests, providing internet access), renouncing attempts to directly force the adult child to make behavioural changes, and recruiting support from their community and network, escalation can be largely avoided.

A parent's description of parent-based treatment for a highly-dependent adult child

We are parents of a severely anxious adult son. His anxiety and obsessive compulsive disorder kept him from living an independent life from a young age and led our entire family to accommodate his anxiety in multiple ultimately unhelpful ways. Over the years, we tried every available treatment, from cognitive behavioural therapy to medication, but his avoidance of school, activities, and social situations continued unabated. Our lives revolved around his anxiety. When people said we were coddling him, we accepted the blame but wondered, "how do we get him to do these things?" No one was able to help, nor did anyone suggest how our behaviour could be changed to achieve an improvement in our son's functioning. Fast forward to his 23rd birthday when we found Dr. Lebowitz and his novel approach to working with parents.

By this point, we were sceptical and bruised from years of failed treatments and from feeling blamed for our son's condition. During our first meeting with Dr. Lebowitz, we were relieved to hear that he would never ask us to force our son to do anything. We had tried this for years and it had never worked. Instead, we would focus on our behaviour by becoming aware of our reactions to our son's anxiety and by making a plan to reduce our accommodations. We started slowly by learning to accept our son's anxiety and to express confidence in his ability to function despite it. We started with our son's frequent daily requests for reassurance. As we began to see some success in decreasing those requests, we addressed a more ambitious goal – having our son get a job. We formally announced this plan to him in writing and began implementing it with small incremental steps, starting with having him apply for jobs. We did not force our son to do any of these things, instead relying upon the natural boredom that resulted from limited internet access as a motivating force.

As we methodically worked through the plan, we began to see that years of struggle had habituated us to viewing our son as not capable of handling difficult things. As we stuck to the plan and had small successes, we grew to see that we were capable of handling our son's anxiety and that our son was capable of handling anything. He could apply for jobs, interview, get jobs, lose jobs and keep a job. The process was not always easy. Learning to resist accommodating him without using force and coercion and by focusing instead on our own behaviour and goals, became the aspirational bedrock of our responses. "You are not in a fight with your child," Dr. Lebowitz continually reminded us. We also broke through years of shame and secrecy by sharing our situation with family and friends for the first time. This provided additional support in sticking with our plan and in de-escalating fraught encounters.

Our son is now working steadily full-time and is working toward living independently. Dr. Lebowitz has helped transform our behaviour and this has, in turn, transformed our son's level of functioning. Importantly to us, rather than blaming us for our son's condition, Dr. Lebowitz showed great confidence in our ability as parents to act as change agents for our son. It is not an exaggeration to say that this treatment profoundly changed our family's lives. We hope it can offer other families an additional and much-needed tool to help them with this difficult problem.

Summary and conclusion

The phenomenon of highly dependent adult children who are not actively engaged in productive occupational, educational, or vocational endeavours is common and challenging for all involved. Parent-based treatment, informed by the principles of NVR and by parent-based approaches for children and adolescents, can provide a practical and potentially

Highly dependent adult children ('failure to launch')

efficacious solution that does not rely on direct participation of the adult child.

This article was written in collaboration with the parent of a highly-dependent adult, who chose to remain anonymous.

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Eli Lebowitz studies and treats childhood and adolescent anxiety at the Yale Child Study Center. His research focuses on the development, neurobiology and treatment of anxiety and related disorders, with special emphasis on family dynamics and the role of parents in these problems. He is the lead investigator on multiple funded research-projects, and is the author of research papers, books and chapters on childhood and adolescent anxiety. He is also the father of three great boys.

NVR and resource-oriented practice: *An empowering pair*

Sven Bussens

Building confidence for non-violent resistance (NVR) action, with the help of resource-oriented practice

A strength-oriented and connecting dialogue with a focus on collaboration, resilience and a more desired future.

I would like to provide a short and practical introduction to how our clients can benefit from the combination of the two frameworks mentioned above, including the mindsets and techniques.

Resource-oriented practice facilitates processes concerning NVR. In this article, my aim is to build hope, choice, trust and awareness through dialogue. In our resource-focused centre, our experience is that when those elements are activated, clients are more prepared and able to think about and practise NVR-related interventions and actions. Clients entangled in destructive patterns have often lost the connection with their own needs and capabilities, leaving them feeling helpless and hopeless. We want to invite them to re-connect with resources and rebuild their strength.

What you select becomes more important in the dialogue and by extension in the client's co-created new reality.

Below, you'll find a practical approach. After the client explains the problem, a dialogue develops.

'John' is 12 and dominates his family. This session begins with his mother telling her story of distress.

"What a story. These circumstances must be very difficult to deal with as a parent. How do you manage?"

The client is invited to connect with her own resources and her role as a parent. She's invited into an active role: an actor who influences her environment. The client receives recognition and an indirect compliment.

"I don't know. I guess I have to. He's our child, you know, our only child. It's normal we don't give up on him. What can we do about it?"

"I can hear that you and your husband care about him. You don't want to give up on him, despite the fact that he has some unacceptable behaviour. At the same time, it takes a lot of effort for both of you to be there for him and help keep him on the right track. Am I right?"

The child's self is disconnected from his behaviour. The facilitator tunes in with the existential wishes and needs of the parent. He also introduces a more NVR-related language.

"Yes. But it's not easy. It's demanding and we have been in this situation for two years now. We tried everything: shouting, punishing, calling the police, … even ignoring him."

"You must care a lot about him. You tried many different things in the hope of finding something that works enough to invite him to change his behaviour. It's clear to me that both of you really want a good future for John. Is that correct?"

Again, the facilitator connects with the existential wishes and needs of the parent. He also recognises the efforts of both parents. The assumption is that a (re-) connection with clear existential wishes as parents contributes to the re-building of strength.

"Yes. That's right. But nothing works, whatever we try. He just stays in bed, refuses to listen, keeps hanging out with bad friends, and so on. So, in the end, nothing is changing."

"Am I right that you're looking for change, that you feel that despite all your efforts, as his parents, the desired change is not forthcoming?"

The facilitator connects with the client's role and efforts as a parent. He's inviting her to shift from "what she doesn't want" to "what she does want instead".

"Yes."

"Can I ask you what kind of change you're looking for? What kind of change will make you and your husband more comfortable?"

The facilitator invites the client to describe her desired future. A clearer picture of the desired future helps to discover precursors of that preferred future today, in the past and in the nearby future.

"Yeah. I don't know."

"I know. It's a difficult question. Is it okay that I ask you to imagine something? Sometimes this helps to get a clearer picture. Shall we give it a try?"

"Okay, go ahead."

"Thank you. Let's suppose that the problem, as we speak about it today, has disappeared overnight. It's unclear how it has disappeared. That's not so important. After all, you were sleeping. What's more important is this: you wake up, as usual, and you notice that something is different, in a good way. What's the first small sign that will tell you that something is different?"

The facilitator invites the client to create a concrete image of the more preferred situation.

"Well, John will answer me when I call him to get up for school. After a few minutes, he spontaneously goes to the bathroom to wash and brush his teeth. When I call him again, he'll come downstairs to have breakfast with us."

"Tell me more. How are you feeling at that moment?"

"I feel calm and confident. I'm happy I don't have to shout over and over."

"How do you notice that you're calm?"

The facilitator explores the state of calmness. This state is important in an NVR context. For the client it can be very useful to recognise this state within herself, and later on create the possibility to go back to that state at any desired moment. If you want to return to a certain state, you need to be aware about how that state looks and feels like.

"My heart doesn't skip all the time or thump like crazy."

"What does this calmness do to your heart? "

"It beats normally and quietly."

"Oh, I see. And what is your husband doing?"

"He's already sitting at the table. He's calm as well and having a cup of coffee."

"How do you notice that he's calm?"

"He remains on his chair and he's reading something."

"How does this affect you?"

"It makes me even more calm."

"I see. Noticing your husband, calmly at the table, makes you even more calm."

Further on in the NVR-process, it can be helpful to be more conscious about how parents can benefit from each other's body language. By addressing this, it becomes more important.

"And you also said 'I feel confident'. How can I understand this better? How do you notice that you are confident?"

"I don't know. I'm doing what I want to do."

"Can you tell me a little bit more about that?"

In an NVR context, it's important to be aware of the fact that the behaviour of the adult is independent of the behaviour of the child. Here is an opportunity to connect with this and make it important by selecting this topic and addressing it.

"When I want to sit at the table, I just do it. When I want to eat or drink something, I just do it. I don't have to worry about John all the time."

"I see. What strikes me in your story about what you want more, is calmness. Calmness seems very important to you. Is that correct?"

The facilitator selects the word "calmness". Calmness is gaining importance.

"Yes. The course of the morning is important for me: it defines the rest of the day."

"Can I ask you another question?"

"Okay."

"Thank you. Can we imagine a scale? Let's suppose the zero on the scale stands for the worst moment concerning calmness. At that point, there is no calmness at all. The further you move up from the zero, the more calmness there is. Now, at this very moment, where would you scale yourself, knowing that this is about a feeling? It's subjective and it's changing all the time. This is about now, this day, this week."

"Phew. Let's say two."

"Two. You chose not to pick zero or below zero. You chose two. That's something. May I ask you why you feel like a two?"

"This week, I had a moment when I felt calmer. Tuesday, I had enough of all the shouting and I went to the living room and sat down in my chair. And, suddenly, I felt a certain calmness. I don't know where it came from. I just had enough."

"That sounds interesting. What happened? What did you do to reach this calmness?"

The client is giving a hint about a situation where she was successful. Here is an opportunity to connect with what already works. It might be interesting to do more of that.

Sven Bussens (Belgium) is a social worker and psychotherapist in the field of solution-focused cognitive and systemic therapy with 20 years' experience. He's a trainer-in-chief, coach, supervisor, author and international presenter as well as the director and co-founder of the Solution Focused Center, Belgium, and an educator at the University College, Ghent (Belgium), in the Faculty of Education, Health and Social Work. Sven has written three books in Dutch: *Waakzaam Zorgen Voor Tieners*, *Ouders in Nesten* and *De Kracht van Het Kleine Verschil*.

He will be a presenter at the non-violent conference *'From Fear to Trust to Cooperation'* in Linz, Austria, on 22 May 2021.

For more information, check out: sven@oplossingsgerichtcentrum.be, www.oplossingsgerichtcentrum.be and http://www.nvr2020.com/speaker/sven-bussens/

If you're interested in the complete dialogue, don't hesitate to send Sven an email.

Beyond parenting: *Therapeutic integration of non-violent resistance and narrative therapy*

Peter Jakob and Sarah

NVR was developed in the context of parenting. However, we hear again and again from professionals that they *"cannot not do and be NVR"*. Its principles have become an integral part of their value systems, have become part and parcel of how they interact with others, professionally and in their personal lives. Controlling, harmful behaviour pervades much of our social interaction, yet there is also a universality of resistance to wrongdoing in its many varied forms. Therefore, NVR has its place in any therapy where injustice persists in our clients' lives; its applicability is not restricted to the realm of parenting.

Ongoing injustice in a person's life often remains unrecognised. This partly lies in the telling of pathologising stories about people who have been – and, though unrecognised, in certain ways continue to be – treated badly. NVR offers a methodology of resistance against ill treatment which, adjusted to context, can be applied universally, while narrative therapy offers ways of weaving new storylines into the multi-layered narrative fabric around the person. This article describes how NVR can be utilised for adolescent and adult clients who have experienced ill treatment and sets out to illustrate some ways of generating synergy by integrating it with the narrative approach.

A young woman, 'Sarah', whose story of resistance is told in this article, shares her own perspective.

Repositioning of the therapist

Many young people who develop harmful or self-destructive behaviours have experienced interpersonal trauma. While it can be unhelpful to attribute each aggressive incident to a vague understanding of 'trauma', controlling behaviour can become a veil that obscures unmet need from parents and adult caregivers, and from young people themselves – acting on angry impulses distracts everyone from their vulnerability and distress.

As children and adolescents grow more mature and their aggressive behaviour diminishes, becoming more able to recognise their own needs – sometimes in the wake of an NVR- intervention with their caregivers – they may engage in therapy as 'customers' in their own right. In such instances, I have also found it helpful to work with NVR. This requires me to change position as a therapist: if before I was the 'parent coach', supporting parents or other caregivers to resist their child's self-destructive or harmful behaviour, while helping them reconnect with the child by re-establishing a caring dialogue (Jakob, 2019), I now become the younger person's own 'resistance coach', as they themselves become the resistor.

Principles and methods derived from non-violent resistance can have their place in the therapy of any person who has experienced and experiences ill treatment. I will attempt to explain the shift in the therapist's position from being a 'parent coach' to becoming the younger person's 'resistance coach' – or indeed the application of NVR across many contexts other than parenting – by introducing a narrative perspective.

Defining the self

To gain access to 'treatment', a person generally enters a child or adult mental health system that provides specific treatments for specific diagnosed 'disorders'. Care pathways are based on diagnoses, which are the generally unquestioned paradigms of mental health care. Systemic therapists in the NHS work within this framework. Diagnoses form stories told about the person. Narratives based on these paradigmatic assumptions can contribute to the harm that is done to clients who have experienced abuse. Deconstructing such a diagnostic narrative and resisting its re-telling can become part of a therapeutic process, along with resisting other interactions that continue to harm or enable harm. Alon and Omer (2006) have cast diagnosing as a form of 'psycho-demonisation' which characterises the person as having some kind of pathological 'essence' – an obfuscation of the actual real-life challenges they are up against.

Common diagnoses for people who have experienced abuse are 'post-traumatic stress disorder (PTSD)', 'depression', 'anxiety disorder' or 'emotionally unstable personality disorder'. In 'PTSD' for example, it is taken for granted that the abuse lies in the past. This punctuation of the narrative enables the clinician to speak of a 'disorder': if the abuse is historic, but the client continues to show high arousal levels, anxiety etc., they must be 'dysfunctional' – they must be getting reality wrong.

Can we see abuse that is deemed historic as ongoing in some way? A perpetrator or others may continue to deny or minimise the abuse or its effects on the victim; the power structures that enabled the abuse to happen may still be in place; justice may not yet have been done. In these ways, ill treatment continues. While these aspects are part and parcel of a wider complex of abuse, the assumption that the abuse is a matter of the past has been made unilaterally by a professional who has been authorised by society to make a determination of the 'patient'. This clinician exerts definitional power over the person (Gergen, 2013), de-contextualises their difficulties and individualises the problem by punctuating the story in an arbitrary manner – one that lays blame for their suffering at their own doorstep. This can also often be said of psychological 'formulation'. While a clinician's narrative may seem more benign than that of the perpetrator, it bears many structural similarities: the person is defined by another who holds power over them; there is only one perspective on the self of the client; the person does not get to choose which perspectives become 'official'; they are characterised as inadequate or 'less than normal' and not as an agent in their own life, but instead as moving through a world that influences them unilaterally.

Such diagnostic or formulative narratives of the person can be harmful and impede the healing process, due to their structural similarity with the kind of narrative the offender has told – or continues to tell by not having retracted. Moreover, stories of the person told by the offender, and subsequent pathologising stories of the person told by professionals, all become woven into the narrative fabric that permeates the social systems our clients live in, and influence negatively how significant others interact with someone who has experienced abuse.

Moving through different narratives

Where serious harm persists – ongoing abuse, threat, denial or minimisation, failure to protect, *as well as/or* demeaning or pathologising narratives of the person that have not been retracted – and dialogue is not yet possible to arrest such harmful behaviour, resistance is necessary.

Pathologising narratives give others permission to treat someone badly or to neglect their needs, as will be outlined further in this article. These narratives are also directly harmful. Their internalisation perpetuates a negative self-concept which exacerbates anxiety, low mood and a sense of isolation. I consider it ethical for therapists to support resistance to the telling and re-telling of such narratives. When, as therapists, we help our clients to resist stories that harmfully define them as pathological – stories which are told by more powerful people – therapy becomes subversive. This positioning may put us at odds with our professional cultures and the institutions we work in.

Narrative therapy develops new, non-pathologising narratives of the person, in which they are described as having agency (Chang, 2019), and they become re-humanised when their own narrative of victimisation is witnessed compassionately (Weingarten, 2003). NVR principles and methods can help clients gain greater agency and self-determination. Their action can then become the substrate of new narratives of their person, in which they then not only characterise themselves as being impacted upon by the world they move through, but also, in a reciprocal process, see themselves as influencing that very world. As a self-defining resistor, they can incorporate many different people's perspectives, centre their own experience and take back definitional power: *"I can tell my own story; I can act; I can say who I am!"*

'Sarah' is a young adult, middle-class woman of multiple heritage whose appearance is white. I am a White male therapist. To illustrate the therapeutic potential of integrating NVR and narrative therapy, I will sketch an outline of her change process (also published in Jakob, 2020):

Sarah is sexually abused at the age of three by a teenage boy. Throughout her youth and into her young adult life, she experiences physical abuse, sexual violence and exploitation. She has dyslexia; the form teacher says that she is academically unable. At 14, Sarah survives an attempt to end her own life. She is diagnosed with 'depression' and 'emerging borderline personality disorder', and receives medication. At 15, she is 'in a relationship' with the 18-year-old abusive 'boyfriend' Roger. Even though she cannot consent and he is committing an offence, no-one objects. In addition to physical and sexual violence, he treats her in a sadistic manner, humiliates her in front of his friends, ridicules her for her fear and shame, calls her "ridiculous" and "stupid". In the family, there is much talk of Sarah's apparent "mental disability", her "unpredictability" and "mood swings". When she communicates her distress from the relationship with Roger, she does not feel listened to. At 17, a psychiatrist writes that she "continues to have contact with several males at a time, whom she does not like", and that this is "the manner in which she relates to men". The psychiatrist does not explore the question, why she would have sex with people she does not like, whether she is psychologically able to consent, does not write that Sarah is being exploited. Family members complain about Sarah's "sudden" angry outbursts, which apparently occur for no reason. Sarah often refers to herself as "crazy", "stupid", a "slag". She suffers from social anxiety, literally loses her voice in university seminars: if they could hear and see her, they would immediately know, what a "crazy, stupid and loose young woman" she is. She has to make herself invisible, inaudible.

We centre unique outcomes (Carr, 1998) *– subplots that don't fit with the dominant narrative – in our conversation:*

Long before starting therapy, she stopped cutting herself; even when she is very distressed, she can resist the temptation to do it again. How does she succeed?

Sarah works with children. How come they love being with her, how come she manages dealing with even 'difficult' kids well? What is she contributing to their lives?

Sarah has good results at university. She doesn't get as angry at her female friends. How does she manage to study? Where does the difference in affect come from?

Working at horse stables, Sarah is liked by her warm-hearted colleagues and appreciated by her employer.

Sarah has a wonderfully dark, subversive sense of humour. We often both crack up laughing.

We talk about these things a lot.

After years, Roger texts her: "I know where you live". "I saw you behind your window". Sarah's traumatic reaction shoots up: fear, sweat, flashbacks, nightmares. In one of her sessions, I work with Sarah on how she could protect herself. At first, it seems incomprehensible why Sarah gets angry at me. It is only on my way home that I realise how I have contributed to the master narrative of her life and personality: the narrative of Sarah as 'mentally disordered', which keeps getting reproduced within her social network, detracts from her psychological injury and from actual threat; people around her get distracted from their responsibility to protect, thereby abandoning Sarah. So do I on this occasion. In this way, Sarah remains unprotected and sees herself as unworthy of protection.

I send her an apology and write that I would like to convene a supporters' meeting, to which we should invite her parents, stepmother and friends. While agreeing in principle to attend, her father hesitates. Sarah makes an announcement, indicating that she will no longer remain silent about his neglect. Finally, a supporters' meeting involving her birth parents and female friends takes place. In the meeting, we attribute her various responses to actual abuse and threat, thereby creating an opportunity for the supporters to become compassionate witnesses. An

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announcement of resistance to Roger is drafted. Whilst Sarah's father still hesitates, he does eventually challenge Roger during a chance encounter. Roger is no longer seen or heard from, and Sarah's traumatic symptoms disappear over a short period of time.

In the session during which Sarah got angry at me, she accused me – rightly – of not listening. Giving this conversational space, her 'rage' becomes comprehensible, makes sense. Her anger shows she has not completely internalised the negative descriptions of her. We 'widen' this 'crack in the wall': therapy becomes subversive, as we 'un-diagnose' (Timimi, 2014) *Sarah and attribute her occasional bouts of anger to the distress caused by ongoing abuse and neglect, rather than to 'underlying disorders'.*

Sarah decides on a 'sexual moratorium', does not have sex with any men for six months. She takes back her sense of having a right to her own sexuality. The belief that she is "worthless", which used to get exploited by men, diminishes, and the sexual exploitation ends.

Sarah's new partner is respectful and treats her lovingly. When she shares her own narrative of victimisation with him, Frank opines that her parents can't have neglected her, "they are so nice". She gets angry. In therapy, Sarah complains about her anger and fears it will destroy her relationship. However, we can understand her anger as a 'symptom of chronic mental wellness' (Renoux & Wade, 2008), *a rudimentary drive to resist. Can we understand her affect as 'outrage', as 'righteous anger'? Could such righteous anger become the drive to resist harmful attributions to her character, to take back the right to her own narrative of victimisation (rather than the master narrative of personal deficiency) and claim ownership of her description of herself? It is important to control one's anger – but this emotion can become transformed into determination to resist. One cannot simply suppress impotent rage, but understanding it as 'righteous anger', as a natural reaction to injustice, supports Sarah's self-regulation. Instead of screaming and ending the relationship, she challenges her partner's position for many hours, impresses upon him how important it is for him to really listen and take her experience as a victim of abuse seriously. She feels moved when Frank later spends many hours reading about sexual abuse.*

The psychiatrist's report elicits further righteous anger in Sarah; she experiences it as victim blaming, an individualisation of the problem. The report has been harmful to her, in that it has maintained her negative self-concept, has fed into the problem-saturated dominant narrative in the family, has distracted family members from her exploitation and thereby contributed to their failure to protect her. She is no longer prepared to accept that the sexual exploitation is not articulated as such, but instead attributed to her as a personality trait. She will not accept that nothing was done by this professional to protect her. We co-author a complaint, which is an announcement of resistance against such practices in CAMHS. After the lead psychiatrist rejects her complaint, stating the psychiatrist in question operated within professional guidelines, Sarah takes her complaint to the next level. She does not want other teenage girls to experience similar treatment and contends that the guidelines must change. Her personal resistance becomes social activism.

Sarah has been studying psychology with excellent results and has completed police training with great success. She would like to specialise in dealing with sexual offences. There is often an upbeat air about her.

Sometimes, family members re-iterate the negative stories about her, such as when they call her partner a "saint" for "coping" with her. The complaint process is dragging on. Sarah experiences social anxiety on the beat. Her story of surviving, healing and resistance has not yet been fully told.

Making sense of rage, generating new meanings

This account of a young woman's therapeutic process illustrates how a pathologising professional narrative in certain ways mirrors previous problem-saturated stories about her – one of which is the story told about her by the previous 'boyfriend', a perpetrator of abuse. All such stories are told *about* her, not *by* her or *with* her. They construct inadequacy, rather than pointing to her abilities, connectedness with others, resources, resilience, and the many positive aspects of her personality. By virtue of this parallel process of telling about her, the professional narrative invites others to maintain positions around her which have harmful effects. Not only do they undermine her confidence in herself, lead to feelings of isolation and leave her feeling she does not belong – they trivialise her experience of abuse, leave her unprotected, and individualise the problems she experiences in the wake of abuse, presence of threat, and persistence of justice not having been done. This amounts to victim-blaming, which contributes to her ongoing ill-treatment.

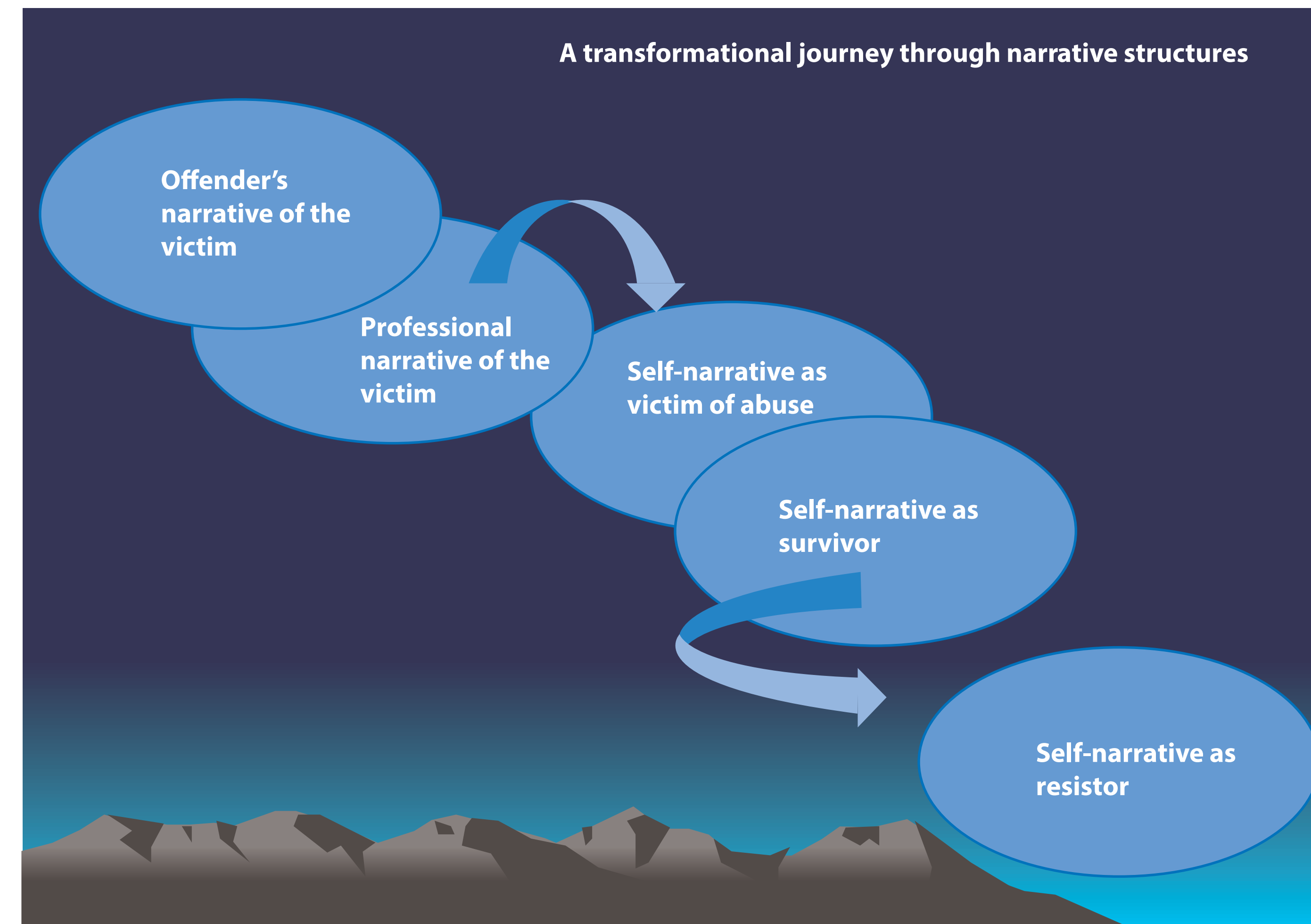
As her therapist, it would be unethical to remain neutral in the face of ongoing abuse or the behaviours of others that enable it. As her 'resistance coach', I find it necessary to pro-actively join her in addressing the different aspects of ill treatment.

One of these aspects is the ongoing sexual exploitation. Sarah's 'sexual moratorium' represents a powerful act of resistance against the de-humanising ill treatment by men who would exploit her.

Initially, in an act of structural isomorphism, I neglect to appreciate her need for protection; learning to understand her anger as a *legitimate* response to this, we then jointly take action against the inertia of family members. The support network which we call together then resists the threatening behaviour of the 'ex-boyfriend'; however tenuous Sarah's father's response may have been, it is effective, both as deterrence, and in reducing Sarah's fear. Importantly, the gathering of supporters also communicates to Sarah, that she is worth protecting. We resist the pathologising narrative by un-diagnosing Sarah and re-interpreting the meaning of her anger. Channelling her anger into challenging her partner's position of not-listening helps preserve this important relationship. As she describes, Sarah resists the retelling of the pathologising narrative to this day, for example when she challenges her father's characterisation of her in relation to her partner. In this context, she also mentions internal, cognitive resistance against the pathologising narrative in the form of 'self-talk' that challenges the negative attributions which she has internalised over time. The complaint made against the psychiatrist's report is a further act of resistance against the re-telling of the diagnostic narrative.

Narrative transformation

There are several transformational stages by which Sarah's non-violent action, and the co-constructed meaning of the action, create new kinds of stories. By forming her own narrative of victimisation, she challenges many aspects of the stories



told of her by abusers, those told by professionals, and those told by members of her birth family: she re-contextualises her behaviour, thereby rejecting the individualisation of her suffering and the negative attributions which amount to victim blaming. This story – and the witnessing of the story by others – is re-humanising, re-establishes her sense of worth, her dignity and her right to be treated well. At this first stage of narrative transformation, she is still seen as being done to, and the story does not yet tell of her agency, strengths, abilities, or her interpersonal connection.

By including elements of resilience and personal growth, the story becomes a survivor narrative. Depictions of 'survivors' are much richer than those of 'victims', which explains why the survivor narrative is a dominant discourse in psychotherapy. That the survivor thrives in spite of abuse, is so much more than even the victim's own story would tell. However, a story of thriving, of responding to the abuse in an idiosyncratic, resourceful way, still implies a one-sided causality: the world impacts on the person, but the person is not yet seen as impacting upon the world.

Finally, by developing a resistance narrative, hers becomes a story of having an impact on that very social world she moves through, which impacts on her. The narrative becomes recursive. In the process of re-storying, her 'rage' becomes re-framed as 'outrage', as 'righteous anger'. By virtue of accepting her anger as a natural response to harmful interaction, then by seeing herself as controlling this anger and channelling it constructively into acts of non-violent resistance, she becomes, for the first time, an agent in her own story. New layers of meaning are attached to the action, such as when she files the complaint with the intention of protecting young girls who come into CAMHS from similar harm – her resistance becomes social activism.

Sarah's perspective

I have spent most of my life hearing people describe me in ways I didn't recognise. This narrative started when I was very young. I can see it hasn't always been malicious, sometimes just misguided and incredibly harmful.

Being dyslexic, I spent a lot of my school years hearing teachers talk about my 'problems' and how I was underperforming from an early age. They would try to manage my parent's expectations and tell us things like I would *"never be able to read like normal people"* and that I should get used to this.

Years later, a psychiatrist told us that I had developing borderline personality disorder and depression. He also said although there were types of therapy that could help, we needed to be prepared that I would most likely be on a lot of medication for the rest of my life.

My parents latched on to anything a teacher or medical professional said, using these narratives to define me as a person.

Being dyslexic shouldn't have changed anything apart from how I was taught at school, but instead, it was taken as something that needed fixing, and because it couldn't be fixed, I was stupid. In the same way, being diagnosed with any sort of mental illness, in my opinion, should not have stopped people looking at each 'symptom'. In my case, it was incredibly damaging, as it gave people an excuse for why I was behaving the way I was, rather than addressing the source of my behaviour.

Beyond parenting: Therapeutic integration of non-violent resistance and narrative therapy

Something was wrong with *me*, no matter how many times I explained why I was behaving the way I was. I often voiced why I was so angry, upset or that something I didn't like was being done to me, but because I was mentally ill it was just part of my illness.

My family, psychiatrists and counsellors did not look past the diagnosis to see there was more to why I was cutting myself, drinking as a child, not sleeping, too anxious to function, and why I had such angry outbursts. Because of this, they missed that it was just because I did not know how to cope with what had happened and was still happening to me.

As I moved further away from behaving like someone with borderline personality disorder or any other type of diagnosable condition, my gender started being used as a way for my parents to try to understand why I am sometimes emotional or angry, and this still continues the narrative that something is wrong with me.

Being repeatedly told by being given various diagnoses that something was wrong with me for most of my life, and not protected from the abuse, left me feeling like something was fundamentally wrong with me and that I was not worthy of protection and not good enough.

The difference is that after a lot of therapy and learning, I now find myself resisting the narrative without any conscious effort. I know I can't change what my family thinks or the stories they choose to tell about me. I now understand the way I behaved in my childhood was a normal reaction to things being done to me and my not being protected or supported as I would hope anyone in a similar situation would be. By no means did it mean that I was mentally ill.

The other day I did not even realise I was resisting this narrative when I sat having tea with my father and a friend of his. He said to his friend *"Sarah's partner is a saint"*. This statement really hit a nerve due to other comments he has made about my partner *"putting up with my mood swings"*. On that day I simply looked at my father and smiled and said, *"He's not a saint, he's a really nice guy but he's not with me because he's a saint; he's with me because he loves me and thinks I am great too"*. I now just feel sorry for my parents as they're missing out on quite an OK person.

It's these small acts of resistance which most of the time I don't realise I am doing any more, that make me realise how far I have come. I now realise my sense of self-worth.

It has taken me years to get to this point and I still find myself occasionally worrying that maybe I am mad, and sometimes I have terrible anxiety, but I can now remind myself that there is nothing wrong with me and that I am ok. I now know that I can trust my reactions and myself.

I am no longer accepting the old *"Sarah is crazy"* story because it's simply not true; there is nothing wrong with me.

The difference is before starting work with Peter, I wouldn't have been able to believe that, let alone find it in myself to protect, reassure and stand up for myself.

Outlook

I have been privileged and deeply moved by being able to accompany Sarah in her process of recovery and resistance and would like to thank her for allowing relational repair between us at those times, when my own efforts have gone wrong. I would also like to thank her for the contribution she has made to developing therapy that can reach beyond 'treatment', and for her contribution to this article. Her courage can inspire many others who are treated badly and have experienced abuse, to become and see themselves as agents in their own, self-told story.

The integration of NVR and narrative therapy is not a panacea for trauma; however, it enables the therapeutic process to develop a synergy that reaches beyond the confines of each individual approach. I hope this article can stimulate conversations about how the principles and methodology of NVR can gain salience throughout our field, not just in parenting.

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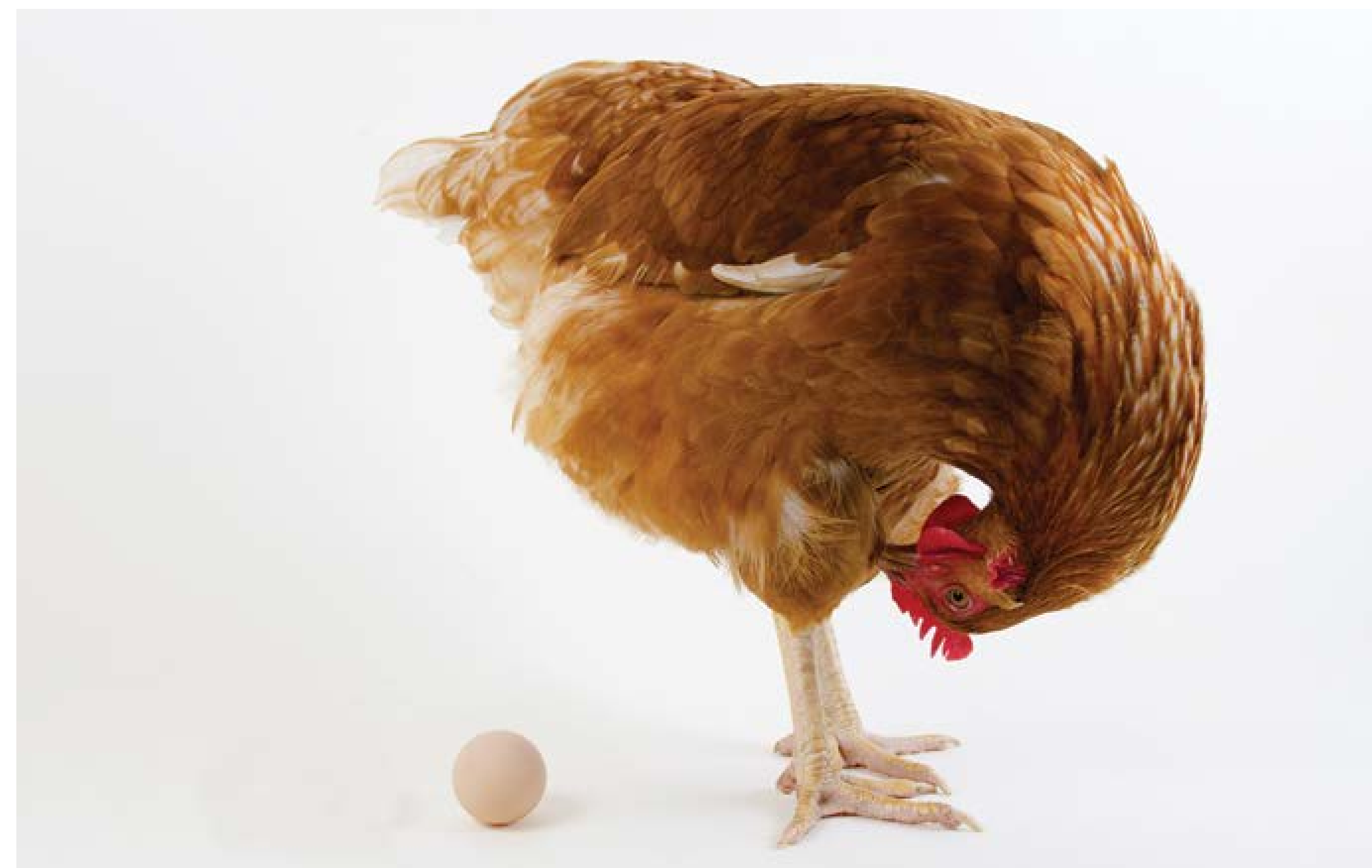
Peter Jakob is a consultant clinical psychologist. With a background in social work, Peter has worked as clinical psychologist and family therapist in both CAMHS and adult mental health for over 35 years, specialising in treating trauma, and children and families involved with child protective services. He first introduced non-violent resistance to the UK and has adapted the approach for heavily traumatised, multi-stressed families and for looked-after and adopted children. His work with traumatised children has inspired him to develop a child focus in NVR. Peter is a prolific national and international presenter.

The chicken or the egg: *Anger, aggression and anorexia*

Joanne Buchmüller and Jill Lubienski



The evidence-based treatment guiding our systemic work with young people where anorexia has entered their family is clear: we generally follow the *Maudsley Service Manual for Child and Adolescent Eating Disorders* (Eisler *et al*., 2016). This approach gives a breakdown of treatment phases; guidance on re-feeding and weight restoration; meal plans; ideas for useful therapeutic conversations and a plan of discharge. It also offers helpful information about meal support. However, as NHS family therapists we are increasingly feeling there is a limit to this helpfulness. Practice-based evidence of this area of our work has led us to notice increasing incidents of violence and aggression from young people suffering with eating disorders towards their family members or carers, and also healthcare professionals, especially during mealtimes. We have heard of an adolescent inflicting their parent with a black eye during a meal and of parents with bruised arms from being repeatedly punched by their child. We have witnessed adolescents verbally abusing family members and parents explaining how they are afraid of their child. We are aware that parents are confused about how they should react. We have heard young people explaining their violence as being part of their "mental illness" and that they are unable to control it. Parents appear conflicted asking, *"Is this my child or the eating disorder committing these acts?"* In their family-based approach, Lock and Le Grange appear to reinforce this and suggest that *"your child is not really responsible for what she says and does with regard to food if she has an eating disorder"* (p. 147, 2005).

Healthcare professionals can be as confused as parents: because re-feeding is seen as the priority treatment focus; violence can be seen as something that can wait. Both parents and professionals can fear that if they seek to address too many issues at once the system will become overwhelmed which will *"make things worse"*. However, there is a danger that parental fear of violence could obscure the needs of the young person, specifically the care needed to support the initial re-feeding process. Lock and Le Grange identify that families where a conflict avoidant (p. 192, 2005) communication style is present may unwittingly maintain the eating disorder. This communication style may possibly also maintain the violence displayed by their child. Therefore the aggression or violence can serve as both the 'chicken' and the 'egg': both a product of the eating disorder and a perpetuator of the eating disorder.

What role does aggression or violence play?

There is little research in this area. Lock and Le Grange's and others' theoretical models suggest eating disorders themselves are a way of regulating emotional effect (Fox & Power, 2009; Schmidt & Treasure, 2006.) We can hypothesise that the child's external expression of anger is an attempt to

maintain self-regulation and so is an expression of anxiety or an attempt to achieve autonomy. We can hypothesise that it is a way to distract attention away from the treatment process. It is possible in conflict avoidant family systems that it is a strategy that works for the young person and therefore is repeatedly used especially in the home where quite often carers are supporting mealtimes in isolation from others. When parents or carers work in isolation parental presence is less visible and mealtimes are a time when parental presence is needed the most. Alternatively, the parent may feel so powerless that they escalate the aggression in an attempt to control the re-feeding process.

Why is it important to address aggression or violence in the family system?

It could be hypothesised that in families where a child utilises forms of aggression or violence as a way of communicating, other family members are acting similarly. This could lead to escalation of violence in the home between all family members. Alternatively parents who are conflict avoidant may avoid participating in the re-feeding process altogether. This article concludes with one parent's view of how and why violence was addressed in their family system.

When should the aggression or violence be addressed?

We suggest it should be concurrently alongside the re-feeding process to avoid blocking treatment. We aim to mitigate the risk that the patient/family member comes to believe that violence is effective and therefore escalates.

How can violence be addressed?

The principles of the NVR model have much to offer families and professionals living and working with eating disorders, and we only briefly focus specifically upon five principles here. Further information about these and the overall model can be accessed here: www.newauthority.net; https://www.haimomer-nvr.com; www.partnershipprojectsuk.com.

1. Parental and professional presence

Parental and professional presence are linked: professionals have a key role in helping parents change and raise their presence around acts of aggression and violence both emanating from themselves and others in the family. When parents feel able to share examples of the violence in the home with professionals and the professionals address this directly both parental and professional presence is raised. Therefore, it is the responsibility of the professional to directly enquire about acts of aggression and violence in the home and express a willingness to assist with resisting this behaviour.

We have found it useful to conceptualise presence in working with NVR and anorexia along the same lines as working with children who present a suicide risk (Omer & Dolberger, 2015). Omer and Dolberger highlight how in overt suicide threats there may be an implicit and/or explicit suicide threat and intimidation of the parent to coerce them into complying with the child's demands. In work with a child with anorexia, the parent has a starving child to feed who they fear will die, perhaps, they think, as a result of their parenting mistakes. Parents can feel both threatened and coerced by their child when the child refuses to eat and threatens the parent. The parent reacts and may escalate with anger or give in or remain passive and/or dismissive. This can perpetuate the problem and increase the overall risk to the child. NVR offers the parent a method to both support their child and resist the violence. It can increase the capacity for parental presence and improve the parent-child relationship. It offers a bridge between attachment-focused therapies and other approaches, and can increase the effectiveness of interventions such as the Maudsley model by specifically addressing the parents' sense of helplessness, parental impulsiveness and parent-child escalation. Omer and Dolberger (2015) identify the process of addressing suicide threats as having two phases: containment and anchoring. In the containment phase, when parents convey presence, a crisis can be contained. This is initiated via the announcement.

> **"NVR was crucial to our efforts to move things forward"**

2. The announcement

The announcement is a written document which details the parents' commitment to support their child while resisting the destructive behaviour, for example the eating disorder, suicidality etc. The announcement is a one-way act to restore the parents' sense of agency and raise their presence in the child's life. Parents can rehearse delivering the announcement and make a commitment to withstand the stress their child's reactions may provoke in them.

3. Use of supporters

The announcement can provide a fresh start for the parents, which includes rethinking what resources are available to them. Parents can be helped to confide in friends and relatives about the eating disorder and their worries for their child, and in doing so develop a supporter network. They can invite supporters to contact the child to convey their concern for the parents and child. Supporters can help parents to withstand the child's violent reactions and convey the seriousness of the life and death struggle the child is engaged in. Developing a network of supporters is important in order for parents to move away from any embedded patterns of escalation and violence and giving in to their child, which can perpetuate the eating disorder. Parents can be supported to actively resist their own impulses to escalate violence and resist violence in others. We aim to move from the argument of whether it is the anorexia or the child who is to blame, towards resistance against coercion by the child in the aim of self-destruction. Over time, parents can become more and more anchored in their role by the support network and by their manifestation of presence.

4. Escalation and de-escalation

Supporters assist the parent in raising and strengthening their parental presence, which can enable situations of reciprocal and complementary escalation to be examined without fear of judgment. Professionals can help focus upon what parental self-control looks like. Mealtime support and parental responses can be rehearsed. The importance of parental self-calming techniques and self-care can be emphasised. Parents are encouraged to consistently give the message: *"We will do all we can to prevent you starving yourself but we know that we cannot make you eat or control you"*. Parents are supported to develop self-control and persistence, and reconciliation gestures made towards the child are woven in to support the parent-child reconnection.

5. Re-conciliation gestures

Reconciliation gestures can help a parent connect positively with their child outside of mealtimes. Anorexia can 'hijack' the parent/child relationship. The child can feel like a hostage to the parents' care, which revolves around calories and meal-plans. Reconciliation or re-connecting gestures, offer the parent an opportunity to establish a respectful, secure relationship outside of the treatment process. Examples of reconciliation gestures are a parent sending supportive text messages throughout the day; purchasing small treats for the child as a surprise or offering to spend time with the child doing an activity of their own choice. These small gestures can both anchor and change the child-parent relationship. A parent who was introduced to NVR whilst her teenage daughter received CAMHS treatment for anorexia explains an example of such a change here.

Therapist: ***How would you describe your use of NVR when managing to resist the anger/violence exhibited by your child whilst you were also supporting them to follow a weight restoration plan?***

Parent: *Because the violence was totally related to our efforts at re-feeding our daughter and controlling her activity and exercise levels, the use of NVR was crucial to our efforts to move things forward. She was using violence to deflect and discourage us from feeding her – and her self-harm was really quite effective. Seeing the self-starvation as the most dangerous part of her self-harming was actually helpful in giving us more courage to tackle it urgently and consistently – even if she would become distressed and bang her head on the wall. Our use of NVR could be described as a fairly long campaign over almost six months, rather than an event or action. The first part was to try hard to reduce our behaviours that escalated her anger and aggression – other than insisting that she kept eating adequately and to try hard to work on reconciliation. Focusing on the two main behaviours, violence and eating, really helped us concentrate our efforts on these two crucial things over the prolonged period of time necessary to achieve re-feeding.*

Therapist: ***Can you give an example of how you used NVR at home when addressing the eating disorder behaviours?***

Parent: *We have applied the whole NVR process in its entirety over a six-month period, during which time our daughter was discharged from in-patient services and has gradually recovered from the worst part of her eating disorder to a point where she is weight-restored and back at school. Each step made a clear and detectable improvement in the atmosphere and behaviours within the home, which resulted in an improvement in the amount of food we were able to insist she ate each day. Taking time for self-care, and being explicitly reminded that it was not only acceptable but necessary for me to allow myself to find joy in other aspects of my life, definitely helped build and maintain my resilience to keep resisting the worst behaviours and making the vital reconciliation gestures to improve and maintain my relationship with my daughter. She was clearly touched and appreciated the announcement we made early on in the process, and both of us as parents at times had to remind ourselves of the promises we made in the announcement not to revert back to old unhelpful behaviours. Recruiting supporters for myself was helpful – and making sure I did report and discuss the violence as it happened helped protect me from becoming a victim of the situation. As my daughter's eating improved and her mood improved a little, recruiting her friends to be her supporters was also crucial. Because of the NVR model and the advice of our family therapist, I had the confidence to approach her friends and clearly explain to them how they could support her in her recovery process – which, in turn, gave them the confidence to know they should contact her and not to be discouraged if she wasn't very receptive to their initial efforts. The escalation of contact from her group of friends resulted in clear improvement in her mood and self-esteem, and a definite increase in her desire to get better and fight the eating disorder thoughts and fight to get "back to her life" and a definite reduction in the hopelessness and despair she had been feeling. I now use reconciliation gestures frequently in the form of letters, small gifts, text messages and quality time consistently and with considerable forethought. I take the time to notice any such gestures offered from my daughters towards me and react and appreciate them for what they are.*

Therapist: ***In what way (if any) has the use of NVR impacted the relationships in the family?***

Parent: *I think the use of NVR has enabled us to separate our reactions to the behaviour from our reactions to our daughter. This has helped us to actively and consistently demonstrate and build our love towards our daughter even when times were hard. This has improved the relationships within the family significantly.*

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Jill Lubienski recently took up a post as a specialist family and systemic psychotherapist working with young adults and their families in the transition service based in the Serious High Risk Eating Disorder team in Cardiff and Vale University Health Board. Jill has extensive experience of working in CAMHS and has an additional interest and specialism in applying NVR with adopted children and their families. Jill is an accredited NVR practitioner, an associate clinician and NVR trainer with Partnership Projects UK.
Email: Jill.Lubienski2@wales.nhs.uk

Please see first article for Joanne Buchmüller's biography.

The chicken or the egg: Anger, aggression and anorexia

Connections which pattern: *NVR feeds an eating disorder programme*

John Burnham, Beki Brain (co-leaders) and 'Juanella' (graduate parent)

Beki to Juanella (graduate parent pseudonym): *You completed both multi-family therapy and NVR parent groups … In what ways do you think you and we were applying NVR principles and ideas?*
Juanella: *During a difficult mealtime my son has 'Anorexia' whispering, or sometimes shouting in his ear, telling him not to eat, or telling him to blame me.* ***I have MFT*** (multi-family therapy) ***and NVR whispering in my ear, guiding me, encouraging me to persist and support my son to resist those voices and to listen to mine.***

Bateson's (1979) notion of *"patterns which connect"* can be used to understand how groups of like-minded professionals create coherent patterns of practice, which may be circulated in the form of manuals, books and training courses. This can sometimes create a silo effect in the name of 'purity' or fidelity to the model.

Thankfully, families sometimes make serendipitous connections which make new patterns between different models and generate improvement in the services they receive from the professionals they inspire.

Irwin Inpatient Eating Disorder Unit uses (multi)-family therapy for anorexia nervosa (Eisler *et al.*, 2016) and multi-family therapy (Asen & Scholz, 2010) to centre the experience, education and empowerment of families in a treatment programme that acknowledges both the universality of the experience many families go through, as well as the uniqueness of each family's journey of recovery from an eating disorder.

In 2009 our Systemic Training Programme commissioned a pan-CAMHS NVR training programme to enable practitioners to respond to interactions escalating beyond verbal containment. The training influenced **both** the culture of the service **and** the practice of individual professionals. Formal training refreshment (2018) across inpatient wards created therapeutic resources in NVR parent groups, and cross-discipline routine practice.

(Multi)-family therapy for anorexia nervosa and NVR were offered selectively, based on the training and preferences of practitioners and the clinical issues for families. Organically, those families experiencing both models blended their own approach and demonstrated the benefits of 'mutual influence' (Weiner, 1975). Juanella beautifully illustrates how she used both multi-family therapy and NVR (Fisher, 2017; Omer, 2004) to support her son in his recovery from anorexia nervosa.

"With the MFT it's telling you how to do it, where to start with the eating disorder, what to do, how to approach it… with the NVR it's giving you the tools to look at yourself, the issues you might have had as a parent. You can address those problems so that you can then help your child."

Approach – method – technique (Burnham, 1992)

Both models are situated within a systemic **approach**. NVR might be said to aim at the reduction and elimination of violence, through increasing non-violent responses to violence. Family therapy for anorexia nervosa is aimed at the restoration and maintenance of nutritious eating, healthy body weight and reclaiming lives from anorexia nervosa.

Both aim to:
- restore, maintain and develop interpersonal relationships: within a family, amongst friends and supporters, and between families and professionals;
- adopt a future-oriented view that emphasises the rehearsal and development of useful skills in preference to attending to a deficit discourse;
- reduce the physical and emotional exhaustion associated with confusion about decision-making, what to attend to first and oscillating between options;
- emphasise caring for self, others and relationships.

Both utilise the:
- wisdom, wit and skills of graduate parents to inform and inspire families who are at an earlier stage in the journey towards recovery and reclamation.
- systemic notion that the part of any system you have most chance of changing is … yourself: parents and carers are encouraged to concentrate on regulating, modifying and developing their own emotions and responses first.

Method

Both approaches use active, purposeful, focused and sometime playful **methods of practice**, including:
Practice mantras that allow parents and carers to enact the approach in their everyday parenting or practice. Some are model-specific whilst others may be interchangeable. For example:
- **Prioritising** when emotional and physical stakes are high is vital, but very difficult for parents and other carers. In multi-family therapy we use **AHHA** (alive, healthy, happy and achieve), created by a graduate parent, which enables critical decision-making. NVR is synonymous with using small, medium and large **'baskets'** enabling parents to devote their emotional and physical energy to their selected priorities. Parents more effectively coordinate their efforts when these choices are made explicit and agreed upon rather than remaining assumed and unconfirmed. 'AHHA' and 'baskets!' become incorporated into the 'local language' of many multi-family therapy/NVR-trained families.
- **Postponing:** 'Keep your eye on the prize' (multi-family therapy) and 'Strike while the iron is cold' (NVR) enable parents and carers to **avoid** being distracted, **focus on** what is important in the moment and **postpone** issues that are not an immediate priority until a time when it is easier to discuss.
- **Performing:** Role plays of problematic patterns are shared methods. Family therapy includes whole-family interviewing, whereas NVR may focus more on parental groups.

Technique:

Rehearsal of particular skills features in both approaches. For example, the preparation and delivery of 'announcements' (NVR) is rehearsed so that important reflections, messages, feelings and proposals for the future have a greater chance of being spoken in a calm and complete way. This also increases the chances of the message being heard and heeded.

NVR contribution to the 'cycle of supported meals'

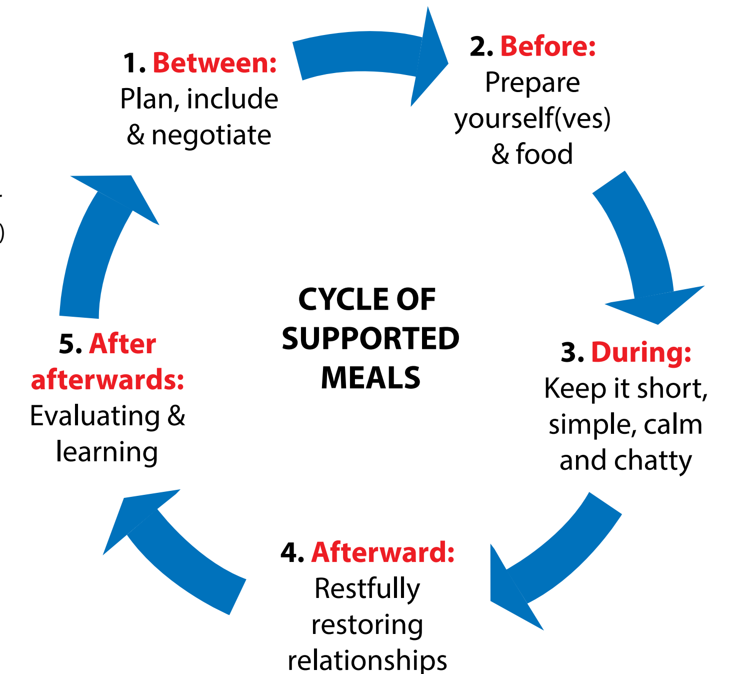
In the early stages of recovery from eating disorders parents gradually develop skills in prioritising **'alive'** and **'healthy'** and postponing 'happy' and 'achieve'. In NVR terms, **'alive'** and **'healthy'** are 'small basket' items. Activities involving 'happy' and 'achieve' become middle or large basket items, **unless** they act as motivators to stay 'alive' and achieve 'healthy'. Parenting during this stage of recovery can be experienced as unexpected and counter-intuitive at this 'expected family life cycle stage' (Burnham, 1986). Expecting teenagers to require less parental direction, exercising more autonomy, and making their own choices is **postponed**. Contrary to what is expected culturally, parents:
- re-take and develop a (re)new authority;
- avoid praise for achievement and acknowledge effort;
- eliminate choice during mealtime;
- reduce autonomy of their son or daughter in relation to food.

An inpatient eating disorder programme is punctuated by up to six meals or snacks, during which a young person is supported initially by a staff member and then increasingly by a parent. Parents may be offering up to three supported meals on the unit and then during home leave. John has composed this map drawing on contributions from nurses, parents, young people and psychotherapists to help navigate a way through this process. Clarity should not be mistaken for certainty.

Multi-family therapy and NVR groups are held separately, and so different skills are sometimes attributed to different models, while this cycle is situated clearly within and using the methods and techniques associated with family therapy for anorexia nervosa approach, Juanella's comments point towards integrating contributions from NVR within this cycle. The five-part cycle punctuates the process of supported meals. The specific contributions of NVR are in ***bold italics***.

1. Between meals: Developing a plan between parent(s), siblings, professionals and young person

Young people consistently inform us that offering choice during 'the (h)eat of the meal' usually leads to unhelpful ***escalations*** of PIPs (pathologising interpersonal patterns) (Tomm *et al.*, 2014): ***'giving in'***, ***'giving up'*** etc. Using the NVR mantra of ***'striking while the iron is cold'*** enables de-escalation, postponing negotiations until a time between meals when emotions are less likely to be triggered by the sight, smell or presence of food and the pressure from the eating disorder on the carer-child relationship. ***Self-care***, as promoted by NVR for parents, carers and siblings is more possible during this stage of the cycle, as is preparing and rehearsing ***announcements*** (mini or major).



2. Immediately before meals: Practical arrangements and emotional preparation

Raising your parental presence by preparing to regulate or manage yourself *emotionally*, come what may. I will remember:
- to do a mindfulness exercise before I leave the car, as I walk into the unit;
- to externalise the anorexia so that I can support my daughter while declining invitations from the anorexia to engage in unhelpful escalations;
- to look and sound confident as I walk into the room and sit down;
- to remember my 'lines' so that I maintain focus on the food;
- that keeping my child 'alive and heathy' are the main aims during this phase;
- that success is not solely judged by what she or he eats.

3. During meals: Stick to plan, with no/minimal negotiation. Keep it short, simple, calm and chatty

Short announcement to set the scene, for example *"We are going to get through this together. Today, I'm not expecting you to eat everything, but I am expecting you to sit up at the table, face the food and try. I expect you to look at me when we talk and not turn away"*. ***Persistence not insistence*** as parental or carer posture is aided by developing a repertoire of helpful mantras within the context of a clear and calm disposition that avoids emotional pleading.
- *"Listen to my voice"* (not *"don't listen to the anorexia"*).
- *"I know it's hard"* and *"Thankyou"* (not *"well done"*).
- *"You don't have a choice, so you don't need to feel guilty"*.
- Don't take insults or other difficulties personally.
- Prompt to eat then chat to distract.
- Regularly remind your daughter or son what you are going to do afterwards (game, watch video etc.).

4. After meals: Restfully restoring relationships with anything but food! Games etc.

Many families feel that their relationship is damaged during a difficult meal. Avoid going over the meal and focus on restfully restoring relationships using ***relational gestures of reconciliation***

Connections which pattern: NVR feeds an eating disorder programme

in creating healing interpersonal patterns (HIPS) (Tomm *et al.*, 2014). Favourite games, movies and knitting are very popular.

5. After meals: What did we learn from that? What will we repeat or do differently?

"How did it go?"; *"How was she?"*; *"Did she eat anything?"* are questions you and others ask to evaluate the success of a supported meal. They arise out of care for your daughter, their sister, their niece, friend or granddaughter. ***Self-care*** is also important, especially in the earlier stages. Step aside from how your daughter did and ask yourself and each other: *"How did I do?" "What did I manage to stick to?" "What did I try to do differently?" "What escalatory temptations did I resist?" "What do I want to build on?"* Keep a journal of the emotional and practical skills you are learning and developing.

6. Between meals: Developing a plan between parent(s), siblings, professionals and the young person

And so we begin to plan for the next supported meal… asking the young person what worked or didn't work for you in the last meal...

Closing words from Juanella

"Helping your child recover from an eating disorder becomes a job. You need to go on training to do that job, and you need a toolbox … They all interlink like a jigsaw puzzle. . . So if you only had multi-family therapy some pieces are missing, but when you do NVR as well the tools go into that jigsaw puzzle and it all becomes one big picture… When different scenarios arise you can pick the tools you need for that particular task. You can use the tools side by side, or one after the other… I don't think our recovery would have moved as fast if I hadn't done both. It would be like painting and decorating, but you only have a roller and no paintbrush."

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Beki Brain is a family and systemic psychotherapist at the Eating Disorders Unit at Parkview Clinic, Birmingham. She co-runs the current multi-family therapy programme there with John Burnham, and regularly integrates ideas and concepts from NVR in individual family therapy for anorexia nervosa sessions.

Juanella (pseudonym) lives in the Midlands with her son, who is still recovering from anorexia nervosa. She is thankful for the help she accessed during the family therapy for anorexia nervosa, multi-family therapy and NVR sessions at Parkview Clinic. She has also found support from the community team and education setting vital.

John Burnham. Please see page 2 for John's biography.

Why we (also) need non-violent resistance: *When the 'gold standard' service offered by early intervention in psychosis services is not always enough*

Mark Batterham, Michelle Mogg, Luke Cousins and Nat Burgess

Psychosis is a serious mental health condition that can halt or partially reverse a young person's transition to independence. Early intervention in psychosis services are experienced in working alongside individuals and families to overcome symptoms and distress and recover a sense of autonomy. Systemic approaches form a key element of the treatment package recommended by the National Institute for Health and Care Excellence. In South West England, we routinely offer a model integrating systemic and family management approaches (Burbach & Stanbridge, 1998). Whilst we have found this model to be effective and acceptable to the majority of families, there is a small number that do not seem to benefit to a comparable extent. Young people in these families often appear excessively reliant on caregivers and refuse many of the treatments on offer, including family interventions. Behaviours displayed by these service users typically include avoidance of meaningful activity, immersion in the virtual world, demands for services from their parents and an inverted day-night routine. This resonates with the concept of 'adult entitled dependence' described and treated by NVR therapists in Israel (Lebowitz *et al.*, 2012). In our experience, these problems often appear during or following the onset of psychosis and are partially perpetuated in the recovery phase by parental behaviours fuelled by a fear of relapse. This contributes to a form of developmental paralysis associated with feelings of helplessness and frustration. Whilst we recognise that diminished functioning and anhedonia are common features of psychotic-type illnesses, we believe that we should strive to overcome these difficulties using any means at our disposal.

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The current, first-line systemic method, whilst collaborative, flexible and optimistic, is predicated on the assumption service users will attend sessions and engage in the therapeutic process. When this does not happen, frustration pervades. In our experience, reasons for service-user refusal frequently relate to an anxiety-driven investment in the status quo. Engagement may also be undermined by residual psychotic symptoms; for example, a service-user hearing voices warning that clinicians are not to be trusted. Families themselves, overwhelmed by the day-to-day demands of caring or fearful of 'poking the bear', may also decline routine family interventions.

We believe the time is right to consider a supplementary approach for families struggling to support their loved ones' recovery. NVR has an expanding evidence-

base across a range of clinical areas (Omer & Lebowitz, 2016). To our knowledge, however, it has not yet been adopted by early intervention in psychosis community services. Our intention is to draw upon NVR principles to provide a structured programme of support to families of service users displaying behaviours akin to adult entitled dependence. We see an obvious reason to utilise many core elements of existing systemic interventions in this field, such as a focus on self-care and attending to the specificity of each family's needs. However, we must acknowledge that current efforts, systemic or otherwise, to address the difficulties outlined above often fall short.

Before introducing families to the repertoire of resistance tactics afforded by NVR, it is imperative to spend time conceptualising the problem together to avoid the risk of caregivers feeling judged or blamed for their loved one's faltering recovery. It is also a necessary first step in challenging any distorted or negative perceptions held by family members in respect of their dependent's behaviour and underlying intentions. Dependence can be variously perceived as helplessness, laziness, or plain bad behaviour, rather than the distress or fear that it is masking. These perceptions reinforce perpetuating vicious cycles, which can escalate when the service user tries to alleviate their distress by pressing for more parental protection and services (Lebowitz *et al*., 2012). Trauma plays a significant role in the emergence of psychosis, resulting in a highly-activated threat system (Hardy, 2017) that can impact on engagement with services. This, in turn, fosters an over-reliance on carers and obstructs the road to independence.

We have witnessed the warmth and solidarity present in our established psychoeducational and support groups for carers, and therefore believe it is important to deliver our proposed programme in a multi-family group setting. NVR is collective in its spirit and methods, so it makes sense for families to come together to learn, share experiences and perspectives, challenge unhelpful narratives and support one another to take action. We see this as valuable in helping families break out of the isolation that can characterise the experience of caring for a loved one with mental health difficulties (Asen, 2002).

Whilst we are proposing a group programme, we remain alert to the danger of standardising a treatment that requires flexibility. With this in mind, we suggest a principle-based approach. We are confident a balance can be found between flexibility and commonality and have achieved this in the past for a different client group (Attwood *et al*., 2020).

We envisage the programme content will focus mainly, although not exclusively, on the following principles fundamental to NVR.

Mobilisation of support

We propose to counter the individualisation and invisibility of caring roles not only by bringing people together to learn but also by encouraging and assisting carers to identify and recruit a network of support from their natural ecology. We see the role of these supporters as being to assist the main carer and to validate their acts of resistance.

De-escalation

Carers can easily become entangled in escalatory interactional patterns. For example, a loved one's refusal to engage in evidence-based interventions can contribute to feelings of frustration and helplessness that can manifest in repetitive arguments, further distancing family members from each other. Reflecting on and stepping out of these circular patterns can be liberating for carers as they move from frustrated attempts at persuasion to planned acts of resistance.

Raising systemic presence

As de-escalation strategies take effect, tensions may ease in the home. Bolstered by inspiration and hope from the group, we will encourage participants to raise their own embodied and emotional presence as well as that of their supporters. By this we mean a calm, persistent and optimistic approach to communicating with their loved one; an approach that acknowledges past difficulties yet points hopefully and determinedly towards a brighter future. This is not about learning to accept and cope with a life sentence. We are instead concerned with mobilising families and communities to push recovery as far as they can.

Refusing orders and breaking taboos

We envisage that much of the work will be directed towards supporting families to identify and address their own accommodating behaviours with the aim of inducing positive change in an approach similar to NVR for the treatment of child and adolescent anxiety (Lebowitz *et al*., 2014). To provide an example, demands for time-consuming lifts from the client lest they experience panic symptoms can maintain avoidant behaviour and leave the carer feeling resentful and inconvenienced. In many ways, this and other elements of our proposed programme chime with the work of McFarlane (2011) in supporting carers to reduce negative bonds between family members and replace maladaptive coping behaviours.

Whilst our proposed programme will require careful planning and critical evaluation, we believe adding an NVR approach to the existing systemic framework will bring hope and positive action to those families not benefitting fully from the 'gold standard' service currently on offer. We have observed the pain, frustration and helplessness of some families as they struggle to support their loved one to achieve a strong recovery. Psychosis can divide families. We believe that NVR can help reunify them.

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Mark, Michelle and Nat are colleagues working in an early intervention in psychosis service in the West of England. Luke is an NVR practitioner, supervisor and trainer based in Bristol.
Correspondence: m.batterham@nhs.net

NVR: *A whole system approach*

Nicky Maund and Lydia Stafford

Looking through the lens of Cronen and Pearce's (1985) coordinated management of meaning, this article will describe how NVR has the potential to influence at all levels of context within organisations, weaving in our own experiences within CAMHS. We (Nicky and Lydia) will discuss significant episodes within the inpatient CAMHS context where we began to introduce NVR (Omer, 2004), and how conversations on a local level have influenced other contextual levels within the wider organisation and beyond. In order to demonstrate how this happened, we will include the voices of the graduate parents (parents who have previously participated in NVR groups) and the professionals we have trained. These recursive developments are ongoing and have resulted in many unique outcomes and sparkling moments. NVR has become a force in its own right in our organisation; those that it has influenced are now those who are influencing through their experience in practice.

Coordinated management of meaning and NVR

Coordinated management of meaning is a theory which can be utilised to understand meaning and influence at different levels of context. Contextual influences (referred to as contextual forces) are likely to be stronger and may be explicit (it's how we do things) or taken for granted (it's the way it is). Within the inpatient context coordinated management of meaning can help us appreciate why the cultural influences of the NHS, wider culture and society can result in a sense of powerlessness at a more local or individual level to bring about enduring change.

On occasions we may step outside of the usually more dominant contextual influences, positioning ourselves counter to these, and thus the lower levels (referred to as implicative influences) can begin to impact the higher levels. In NVR terms this might be viewed as an act of resistance and various ways in which individuals can activate support to raise presence and bring about change within themselves, relationships, their own family and then other families, and so the influence grows. NVR in the socio-political field illustrates how conversations at a local level can begin to influence and bring about change in culture and societies. There are many examples of this through history and, in the words of Mahatma Gandhi, *"In a gentle way you can shake the world"*.

Background context

We completed NVR training in 2013 when we both worked at Parkview Clinic, the regional inpatient CAMH service in Birmingham. Following the training we worked in separate organisations, in different parts of the country. Within these different contexts we independently started at the same point: implementing parent groups and introducing NVR informed thinking as a way of raising the presence of staff alongside parents to resist challenge and strengthen relationships. We came back together at Parkview in 2018, having arrived at the same conclusion about the potential for NVR to influence the whole system within which we worked. This was, and continues to be, influenced by many factors but most powerfully by the parent and professional graduates who discover for themselves the potential of this approach.

One parent graduate has written the following:

> *"I first encountered NVR when my daughter was very ill with anorexia in Parkview Clinic.... she and we were at a very low ebb indeed, close to despair I would say; and we were all frightened that she might die.*
>
> *My wife and I were finding it very difficult to manage... as there was so much negative emotion on both sides. The more agitated our daughter became, the more agitated we became also; and our approach to each other was clearly non-productive. We had to find a new means of communicating ...but we did not know where to turn.*
>
> *Then we were invited to participate in the NVR group, which had been set up in Parkview for parents of children in all the constituent wards...*
>
> *I must confess I did not go to the first few sessions and was persuaded to do so by my wife, not because she asked me to but because I could see a huge and positive change in the way she was now able to manage and I felt that I had to play my part. She managed to defuse highly emotional situations just by being calm and communicating (and often not communicating but just offering silence). I then signed up to the group and have been attending sessions both as a parent and a graduate parent for the past two and a half years. During that time a minor miracle has happened: our child...was discharged after ten months and, despite many wobbles since, did well enough to pass GCSEs and is now studying three subjects at 'A' level. Much of this is down to the fact that we now know how to communicate.... in a way which is non-threatening to us and to her. We are no longer constantly afraid of what she might do next and she is responding to us in a much more positive way.*
>
> *What I have found so different about my NVR experience... is that it is a coherent philosophy and system which has enabled us to be reconnected to a daughter I thought I had lost forever to mental illness. NVR above all restored my faith and my confidence to handle my child in a positive way, and enhanced my ability to manage the eating disorder itself. ...It is no exaggeration to say that, if it did not save our lives, it certainly saved our sanity. It is true to say that at one point we all were suffering from anorexia. Now anorexia is something we know will probably never entirely leave us in peace but it is manageable and we can again get on with our lives."*

Parents have, time and again, shared similar testaments about the difference NVR has made to them and their children; how relationships have improved and how they have been able to resist the negative aspects of their child's illness and galvanise their resources to focus on recovery.

Parents also told us how confusing it was when they were implementing NVR and the ward staff were not. Ward staff felt disempowered that parents understood something they had minimal knowledge about. Staff members were de-escalating, often without appreciating the need for increasing presence and active resistance. Staff would use the language of NVR without always fully understanding what this meant. They would sometimes say things like, *"NVR doesn't work,"* which was a clue that it was being seen as a technique to apply rather than a relational approach and philosophy. The contextual forces of a behavioural approach so prevalent within

our wider culture, and the idea of fixing and treating problems, was influencing staff expectations.

Implicative influences: parental and staff feedback

We reflected on the influence of NVR within our organisation since 2013. We realised many of the people originally trained in it had left; the language of NVR had remained but the understanding of the overall approach had not and this was damaging the reputation of NVR.

We had come to appreciate the huge potential for symmetrical and complimentary escalations within teams, between young people and staff, and staff and parents, in the absence of a coherent approach. We had also come to appreciate just how difficult it can be to influence the entire culture of a team, service and organisation, and this required ongoing persistence. We had experienced specific episodes when a coordinated and coherent approach in raising the overall adult presence for young people could close the gaps between all, and maximise resistance to the controlling and destructive aspects of the mental health difficulties. We concluded that the piecemeal training of some staff in the hope this would influence whole teams and beyond was not enough; it relied on individuals, and coordinated management of meaning gave us a way of understanding why, despite many sparkling moments and unique outcomes (White, 1990), changes within teams and the wider clinic had not been sustained.

Conversations and episodes

An opportunity arose to do things differently. A plan to include foundation level training as part of the local MSc in systemic psychotherapy, created an opportunity to train a number of inpatient staff at minimal cost.

We were fortunate that alongside the head of systemic training we were able to deliver this training ourselves in partnership with an accredited training organisation.

In the spirit of NVR, we enlisted an influential supporter – our head of nursing – and wrote a service proposal, which stated our vision, the evidence base and expected learning and service outcomes. Our overall priorities were improving staff and parent or carer wellbeing and outcomes for young people.

Back in 2013, a number of staff were trained from one of the units. This time and in order to achieve our vision of a *"whole system approach"*, participants were identified who represented all disciplines AND were in positions of influence at all levels of the system. We realised that we needed to recruit supporters, and that without this we would not be able to generate the influence necessary to realise our ambitious plan.

Training episodes

The feedback from the first training inspired us to continue. It included the following, from a deputy ward manager on the final day of the foundation training *"…what we are talking about with NVR is a change to the culture of the service, and what I have come now to understand is that the responsibility for this is within ourselves. We can only take responsibility for ourselves to effect this change through NVR…"*

This motivated us to find other ways of delivering further rounds of training through partnerships with accredited organisations. We wanted the training to comply to standards and be recognised so that as part of an overall strategy, identified staff members could go on to do advanced training and eventually go on to be trainers themselves.

We adapted the training to fit with the standards but in ways that were also adapted to fit the context. There were opportunities to consider how to implement NVR across the service and within all relationships: for example, splitting into groups to think about NVR in relation to parents and in the supervision and line management of staff. We encouraged the unit teams to consider the principles in relationship to young people on the wards and within these groups the staff prioritised behaviours to resist; wrote announcements (for young people and parents) which they subsequently delivered and were then able to think together about how to do 'sit-ins' on the wards. The 'sit in' developed into 'sitting with' and how this could inform everyday levels of observations young people are placed on. In other words, we considered both changing everyday practices and changing ways of doing the everyday practices to incorporate NVR principles.

In the first cohort we trained 26 key members of staff and asked for written feedback in response to the questions *"What has been most useful to you and why?"* and *"What is your small basket priority?"*

Themes emerged which are highlighted in some of the many examples shared below.

1. The practical application of the approach

"The ease of application and ways it can be used in own life as well as on the wards."

"Baskets – applicable to every aspect of ward life. Fantastic concept."

2. An increased understanding about the approach and its application within the inpatient setting

"Sounder knowledge of the theoretical underpinnings, experiential learning and an opportunity to think about how NVR can become an underpinning framework for the whole clinic."

"Expanding my understanding of its application to different relationships; not just parent/child dyad."

3. A renewed energy and enthusiasm

"The use of role plays and examples have really brought the skills and techniques to life. I am looking forward to putting them into practice now I have these examples in mind."

"I can't wait to share with the rest of my team."

4. Staff both understanding the vision and thinking about how to move this forward

"Parental presence on inpatient wards and strengthening relationships..."

"Practice and look at using baskets more in care planning."

"Thinking about what staff training looks like going forward."

"To start to use the language and approach in communicating with the team."

"Joining in with developing announcements for young people on the wards."

"Work out my small basket in terms of the team needing training to ensure this is an approach understood by all."

The implicative influences of the initial training within teams, the wider organisation and beyond

Following the initial training, Lydia left to take up a new role in Early Help Mental Health. Lydia wanted to replicate what we had achieved within the inpatient setting and we went on to train 50 more staff from both teams and partnership services.

The feedback from this training generated similar themes and was additionally beginning to develop beyond our initial vision. This training has resulted in further developments including the setting up of parents' groups at an early stage in the presentation of their children's mental health difficulties across the city. One professional graduate wrote:

"It could be really revolutionary...we could potentially use this to inform, improve and drastically alter our school refusal approach within the city..."

The influence is spreading like rhizome roots under the ground with the latest new shoots including interest from public health commissioning.

The contextual force of COVID-19

COVID-19 has impacted on all levels of context and has required us to readjust our expectations. Staff teams are depleted and feeling the reduction of systemic presence. Despite the challenges, the influence of NVR has continued and we have adapted some of what we do. We have run separate but simultaneous virtual NVR parents' groups in our different services. We pooled resources so the teams could act as supporters to each other and this has resulted in unexpected outcomes, such as enabling a greater number of parents to attend than ever before.

The implicative effects on culture

Parents and staff have become both supporters and implementers of NVR as we persist with our original vision of a whole-system approach.

The following testaments speak to the changes within the culture of our service. The first testament is from a dad who has helped in the delivery of training to staff and the second is a mum who attended the virtual NVR group, and perhaps illustrates that although we are not where we hoped to be as a result of COVID: the influence of NVR has persisted. In the words of Martin Luther King, *"Change does not roll in on the wheels of inevitability, but comes through continuous struggle"*.

"I was invited several times after my daughter's discharge from Parkview Clinic in April 2019 to speak about the effectiveness of NVR as a philosophy to the medical and nursing staff from a parent's perspective. I was very pleased to do so because it seemed to me wrong to limit NVR training just to parents; this ran the real risk of those various professional and family groups…working through quite different principles (and not always parallel channels) of communication. It is gratifying now however that, less than two years on, the NVR approach has been widely embraced by the professional staff to the benefit of themselves as much as to the benefit of the children and families they care for."

"Looking back on my daughter's time at Parkview, I felt confident that staff and family were working together and using the same

approach. My daughter had plenty of interactions with the nursing staff and she would often comment on discussions she had, who she liked, how people had helped her. It was helpful to know that when we talked about striking when the iron is cold, everyone understood what that meant. Sometimes, staff would encourage us to still visit when she was refusing to see us. Having completed the NVR training, I see how this was raising our presence and the positive impact this had on her. When she was really struggling with feeds and how she was feeling afterwards, I felt that I was working with the staff ...although we were unable to deliver the announcement due to the transfer to another hospital, I felt that we were working together and that this would only benefit my daughter."

"I have now seen things from a different perspective and see big differences. In the new unit, I feel that the support staff (rather than the qualified staff) have more of a presence on the ward, because they are the people my daughter talks about. There have been occasions when the nursing staff have tried to engage with her to change an escalating behaviour when she is 'hot'. When I explained that it would be better to do it when she is calm, it felt like an idea, which hadn't been considered. Recently, I was due to visit her and continued the journey even though she said she didn't want me to. Staff had tried to ring me to tell me not to come. When I arrived at the unit, I let the staff know that I would be waiting in the car in case she changed her mind, which she did. I used a reconciliation gesture, raised my presence and encouraged her sister to do the same. We were able to see my daughter because of this, and if I had received the call from the staff, I might not have done so. I feel that working as part of a team is also part of NVR, with the staff being my support network and us working together to show a united front to my daughter."

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Nicky Maund is divisional lead for systemic family therapy and Lydia Stafford is a senior practitioner at Early Help, Birmingham CAMHS, where they provide NVR training through their organisation Raising Presence UK. Email: nicky.maund@nhs.net and lydia.stafford@nhs.net

A thousand battles

Sarah Cole and Carole Payne

> **"It is better to conquer yourself than to win a thousand battles"**
>
> **Buddha**

This article is set in the context of a tier four adolescent forensic psychiatric inpatient unit. Patients, between the ages of 12 and 18 years, have often been both the victims and the perpetrators of many types of violence and staff can be on the receiving end of violence, either in the moment or vicariously.

When the unit first opened, many of the staff came from adult psychiatric units or prison services. It took a while for an adolescent-focused culture to develop. A model of care based on attachment and trauma theory was developed and the focus on least restrictive practice increased. As staff tried to find the balance between appropriate authority and relational connection, NVR, being used increasingly and successfully in the local CAMHS, seemed an ideal approach to implement within the unit.

Goddard (2014) comments that a ward, like a family, is a system in which there needs to be a unifying version of care, which is implemented consistently by all staff.

Having undertaken practitioner and then trainer training, we began by introducing a three-day foundation course which all unit staff members were rostered to attend. There were difficulties in releasing ward staff for training due to the shift pattern and regular high acuity within the unit. NVR seemed to be like Marmite – staff either loved it or hated it. Those who found the concept most difficult generally expressed doubts about the idea of 'relationship' and struggled with the perceived lack of 'consequences' for young people whose reactions can create emotive responses within the staff themselves. Staff could find themselves fearful of the young people, which evoked feelings of powerlessness and reduced staff presence. The 'caring dialogue' was often then reduced (Jakob, 2014).

Others found the approach extremely useful and we decided to run a practitioner training for a group of multidisciplinary staff. It was during the teaching and marking of this course that we noticed many reflections from the group on their realisation of the importance of the need for greatly increased levels of self-reflexivity (Hoffman, 1992) within staff before NVR approaches could be successfully implemented, and familiar escalation cycles between staff and young people avoided.

At the same time, Sarah was working with Jill and Lisa (names and some details changed). Lisa was 17 when she was admitted to our service having attempted to take her mum's life. She had planned the attack three weeks previously, and carried it out before being arrested by the police. In the past, Lisa had been seen by CAMHS for anxiety and suicidal ideation, with no history of violence. Jill didn't want to be afraid of her daughter and was developing a growing awareness of the need to reflect on her own feelings and responses.

We began to be aware of the isomorphic process in increasing self-reflexivity between all parts of the system, and particularly to think about our own part as trainers. We wanted to move to an 'alongside' position with the staff team, from which we could increase support most effectively as they tried to implement NVR.

On admission, Lisa presented as traumatised, emotionally unregulated and hyper-vigilant. Fear showed itself through aggression and self-harming.

Lisa's relationship with her mum had completely broken down following the incident. Lisa spoke about internal conflict as she had not 'finished the job'. There had been one supervised visit with her mum since the incident. Risk to mum and Jane, Lisa's older sister, was considered to be high; risk management became the highest context.

When Sarah met with Jill, she presented as a gentle, intelligent, articulate lady who had experienced an unprovoked attack, out of the blue, from a daughter who was loved and well cared-for. She was completely traumatised. She refused to press charges and said she wanted to be part of her daughter's recovery.

As a team we discussed the risks of undertaking family therapy and considered how this could be managed. Sarah noticed parallels between the concerns of the staff team regarding the potential risks towards the family from Lisa, creating resistance to starting therapy, and the family's reluctance to discuss their time with dad, Daniel. Jill and Daniel had separated when Lisa was three.

The process began slowly. Sessions were planned to reduce risk. The sessions included Lisa, Jill and Jane. Lisa began to tell her story, which had not been shared as a family due to unwritten rules which had developed between the two siblings. It was noticeable that, when speaking about her time with dad, fear struck Lisa, almost disabling her into a position of disempowerment.

Carole Payne

Sarah Cole

Lisa's strength in beginning to discuss her childhood experiences with dad appeared to help empower Jill. There was a noticeable shift in positioning within the family as the work developed. In reflective practice with the team, we thought of the ideas of Harre and van Langenhove (1999) on positioning: we not only position ourselves in a certain way and invite a response to this, but are also positioned by others. We can accept or reject the offered position. Initially there was a palpable feeling of dad's power in the room; a figure, not physically present, but holding the rest of the family in a position of powerlessness. Daniel's control over the system unfolded through the stories, now told by both girls. Jane had positioned herself differently with dad, aligning with him in order to try and stay safe. Her relationship with mum had suffered as a consequence. Jill began to reject the powerless position which both Daniel and Lisa had offered her. Noticing this, staff began to consider how they were being positioned by Lisa and other patients. Could they also begin to act into a position of greater authority?

The NVR approach brought about a huge positive shift for this family. Mum introduced relational gestures to begin to reconnect with her first daughter. The aim was to try and strengthen this system, reducing the legacy of dad's power. Lisa had stopped seeing dad earlier in the year. Jane was still seeing him, seemingly due to her loyalty to him but also in fear of the consequences of not seeing him. This worried Lisa.

Jill moved away from anger and fear of dad to a more strategic and empowered position. She found supporters to help her and learnt to be honest with her own family of origin about what had happened. In keeping with Omer's (2011) idea, Jill began to 'radiate authority' as she sensed it in herself. Lisa experienced her mother as a stronger presence. She was able to acknowledge that she had viewed mum as weak for some years, feeling very angry with mum for making her visit dad. As the work progressed, Lisa's anger dissipated, she was able to accept mum as a carer rather than a persecutor.

As mum regained authority, Lisa experienced increased emotional containment. In parallel, becoming more aware of their own responses, the team were also able to de-escalate more effectively, with a reduction in violent incidents from Lisa. We could see these patterns replicating across sub-systems: family and staff. We began to notice this having a positive impact on staff approaches with other patients.

With this casework in mind and drawing upon the experience of exploring the use of NVR in greater depth with a group of staff, we reflected on changes which we could make in teaching NVR, in order to support the ongoing growth of staff self-reflexivity and their repositioning in relation to violence.

Teaching on self-reflexivity was expanded in the foundation-level course. In NVR supervision and reflective practice the emphasis on self-reflexivity was also increased, supported by the presence and ongoing practice of the NVR practitioners. As unit staff-members were able to experience NVR practitioners modelling greater self-reflexivity and notice the effect on their day-to-day practice with young people, we noticed a slow but steady shift in confidence in using NVR techniques, in both language and actions.

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Sarah Cole is a family therapist and Carole Payne is a family therapist and systemic supervisor, both currently working in a forensic adolescent unit.

Making positive changes for supporters in NVR practice

Stephanie Hicks

Non-violent resistance (NVR) is an approach which relies on building a supportive network around the family in order to increase parental presence and agency (Omer & Lebowitz, 2016). By providing practical support to the parents, increasing transparency around violence and ensuring parents do not feel alone in delivering the approach, interpersonal support has been identified as a key predictor of success in NVR (Attwood, Butler & Rogers, 2020). With supporters involved, parents have described feeling that they have the strength to start resisting violence (Shapiro, 2014).

Two years ago Peter Jakob (director of Partnership Projects), Claudia Kustner (clinical psychologist, University of Bath) and I (Steph Hicks, trainee clinical psychologist at the University of Bath) set out to complete some research exploring the perspective of supporters involved in NVR. The project was requested by Peter, who wanted to understand how supporters experienced taking part in this approach and find out what factors helped them feel engaged and motivated to take part. From interviews with eight supporters we were able to draw up a list of suggestions for improvement to the delivery of NVR which we felt would increase their engagement in future (Hicks, Jakob, & Kustner, 2020). The suggestions were as follows:

1. Help supporters to develop their understanding of NVR.
2. Provide clarity on the type and level of commitment required for the supporter role, potentially with other supporters sharing their experiences.
3. Help supporters prepare for the emotional demands of the role, considering their own coping strategies and support network.
4. Communicate to supporters regularly about any positive changes in the child or family.
5. Provide supporters with positive feedback on their performance.
6. Nurture relationships between the supporter and the family and/or child, ensuring any ruptures are dealt with.
7. Allow supporters to link up with other supporters for peer supervision and/or validation of their experiences.

The research project was completed as a 'service improvement project' for my doctorate in clinical psychology. and requested by Peter with the aim of making improvements to the way in which Partnership Projects engages supporters in NVR. Two years on, I find myself wondering whether the suggestions translated into practice. I hope providing reflections on this from two perspectives might illustrate how research can result in positive changes in practice.

Firstly, I have attempted to put myself back in the mindset of having just finished the research, in order to share some of my reflections before the suggestions were implemented ('before'). I have then written up a discussion with Peter on trying to implement these suggestions in Partnership Projects over the past two years ('during'). Subsequently, I have returned to my own reflections after hearing about the progress made ('after').

Before

This was the first time I had completed a research project directly with a service and it felt like such a satisfying way of working. As the project was designed around something Partnership Projects was keen to improve it felt purposeful and clinically relevant, yet I was surprised by the lack of research into what is described as such a key part of the NVR approach. Both Peter and I were keen for the research to relate directly to what Partnership Projects was interested in and so we tailored the research questions and methods as such. It felt as though the research had the potential to guide Partnership Projects on how they might improve their practice of NVR.

I was conscious of coming to this research without much understanding of NVR. This increased my ability to be curious and take up a non-expert position in the interviews with supporters, but made me feel blind to the other perspectives in the system (e.g. parents, practitioners and young people). By the end of the interviews I felt embedded in the perspectives of the supporters I spoke to. By holding power as a researcher for the service they were involved with, it felt as though I was helping them raise their presence in the system and ensure their voices were being heard.

Reflecting on the experiences of supporters it was interesting how the themes showed a need for them to increase their competence and sense of achievement in the NVR approach. It felt as though they were sharing the journey with parents in building presence and mastery in responding to the young person's behaviour, yet without the rest of the system necessarily acknowledging this. It struck me how easy it is to focus on the changes which need to be made by the parents in NVR, potentially at the neglect of the steep learning curve which supporters also need to tackle.

At the point of drawing up the list of suggestions. I felt like the research was on track in providing tangible ways in which improvements could be made. Interestingly, although the research question related to improving the motivation and engagement of supporters (from a practitioner's perspective), I instead felt more like I was allowing the needs of the supporters to be heard (from a supporter's perspective). All the suggestions had been developed directly from the experiences of supporters and, at the time, seemed like things which could be implemented relatively easily.

During

Discussion with Peter – director of Partnership Projects

Peter said he wasn't surprised when he saw the list of suggestions for improvement, but experienced more of a shift in emphasis in what he needed to focus on with supporters and families. He talked about how he has always emphasised to parents that they need to avoid a 'complaining' narrative with their supporters, and instead feed back their own successes in raising presence. He has always emphasised this as a way to prevent compassion fatigue and helplessness in supporters, as they are able to hear how the behaviour of the parents is changing. What he found most interesting is that supporters really felt the need to hear about changes in the child's behaviour, as this seems to be how change is measured in their minds.

Since the research project was completed, Peter has asked parents to share more with supporters about changes in the child's behaviour, yet has aimed to balance this with the existing mentality of success over one-sided action. Peter talked about the importance of parents seeing themselves as successful in what they themselves are able to do in spite of rejection, aggression or dismissive responses from their child. If parents are too focused on how the child reacts in the first instance then they become disempowered. Peter's aim is now to encourage more feedback to supporters about positive changes in the child, whilst encouraging feedback about positive changes in the parent's efficacy even when changes in the child may not be apparent.

In relation to nurturing the relationship between supporters and the family, Peter's experience is that ruptures are more that a fear supporters have than a reality. He explained how in practice and over time, relationships between supporters and the parents/child tend to get closer rather than seriously ruptured. Peter has however found that emphasising positive feedback over negative feedback has resulted in supporters appearing more confident and engaged in their role. Peter uses a 3/1 rule and has been discussing this with parents more as a result of the research. This rule ensures that the supporters (and child) receive three 'positive messages' for every 'problematic message of concern' in NVR.

We discussed how Peter is now moving beyond the 3/1 rule in his training and practice, as he has found that change in parental efficacy and child behaviour seems possible with exclusively positive messages.

Peter has started talking with parents and supporters about two types of positive events – 'exceptions to the problem' (when a problem behaviour was expected and didn't happen) and 'thrive' events (where new behaviours are developing in the child or relationship). Peter often uses a metaphor of emerging 'green shoots' for thrive events which both supporters and parents have taken on board.

The suggestion which Peter has not yet been able to implement is the idea of peer supervision for supporters. He plans to discuss this with colleagues at Partnership Projects, as he feels it will need careful consideration about how to do it safely and avoid the build-up of a 'complaining' narrative. He is unsure whether the peer supervision idea will work, but has had other thoughts around supporter podcasts or YouTube videos as an alternative way for supporters to share their experiences.

Overall we discussed the ways in which Peter's own practice has changed as a result of the research, but also how this is then being disseminated through training and supervision in the organisation. As Partnership Projects provides NVR training and supervision across the UK it is hoped these positive changes in practice will also be adopted by NVR practitioners more widely.

After

After my discussion with Peter about implementing the suggestions for improvement I felt that, from a practitioner's perspective, the research had been a success. The suggestions for improvement have resulted in positive changes for the whole system implementing the NVR approach and will hopefully be adopted more widely through supervision and training.

In reflecting on my discussion with Peter I found myself wondering what the perspectives of supporters would be on the changes that have been made. Looking back at Peter's comments, I can see how embedded I had become in the experiences of supporters by conducting, transcribing and interpreting their interviews. I wonder if they would be frustrated that ideas such as peer supervision haven't been implemented, or whether they would share Peter's view on the difficulties of translating this idea into practice.

Despite the overwhelmingly positive changes described by Peter, I'm aware of how I am drawn to the suggestion which hasn't been implemented. It seems that as a researcher, 'success' in my mind has been framed as ensuring each and every suggested change actually happened – easily neglecting some of the practicalities which I might be more aware of if I was working as an NVR practitioner. It is interesting to remind myself that the research was initially designed entirely from the perspective of the practitioner, yet this is not a perspective I was able to keep in mind as a researcher with no personal experience of delivering NVR.

Moving back to the positive messages from Peter about changes in the service – it's amazing how something as simple as the 3/1 rule can make such a huge difference in efficacy, engagement and outcomes in NVR. This simple message can be applied to almost every interaction in the system around a young person and seems to create a new narrative which allows 'green shoots' to emerge. Applying this to research, I wonder how my results would be different if I had applied the 3/1 rule in my suggestions for improvement – would there be a change in the narrative within Partnership Projects if I had used a similar strategy rather than simply suggesting ways in which improvements could be made?

Final thoughts

I hope this paper has provided an inspiring example of how research tailored to specific service needs can result in positive change, whilst also helping other researchers reflect more about differences in perspectives across a system, and how the success of a project might be defined when all these perspectives are taken into account.

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Steph is a newly-qualified clinical psychologist working with children and young people in South Oxfordshire. When the research was completed she was a trainee clinical psychologist at the University of Bath. Email: steph.hicks16@gmail.com

NVR UK; Past, present and future: *Reflections*

Aimi Willmer, Dawn Oliver, Elisabeth Heismann, Liz Day, Julia Jude, Sue Dromey, Michelle McCarthy, Margaret Smith and Denise Wilson

The foundations for NVR UK were in July 2011. Ten early-adopters of NVR met to discuss ideas for promoting and supporting the delivery of NVR in the UK. All were developing it within their settings (CAMHS, social care, education, community and residential), offering individual or group programmes.

We established five broad aims:

- Promoting the development of NVR as an approach.
- Supporting good and innovative NVR practice, developing resources, interest groups and hosting NVR conferences.
- Promoting and coordinating research and developing tools for collecting outcome-measure data.
- Accrediting NVR practitioners and training.
- Connecting with the international NVR community.

The inaugural meeting was on 17 February 2012, covering the following:

- Training, certification, supervision, accreditation.
- Public profile, conference, resources to promote NVR practice.
- Constitution.
- Parent participation.

Steering committee officers were elected and subgroups formed. From its inception, parents were not only actively involved in the steering group but formed an indispensable part.

2014 was a milestone year for NVR UK with the first national conference. The profile of NVR was raised by a special issue of *Context* magazine. Over the years, we developed a website, hosted three national conferences and promoted NVR values in responding publicly to matters like knife crime. NVR UK members and parent practitioners have attended and presented at international conferences and showcased NVR in a variety of publications (books, articles and a thesis). NVR UK has developed standards and structures for training and supervision. It has been a slow and sometimes rocky road, calling for persistence.

As with all therapeutic approaches, an NVR practitioner begins by making a therapeutic alliance (Johnson, 2002) or, in NVR language, making a connection. However, a significant difference in NVR is the connection is only made with parents and caregivers, who are regarded as a conduit to change within the family system. The ability to bring about change within the family and network, without ever meeting the child, is one of the benefits of the NVR approach. However, there are situations in which therapeutic work with the child happens alongside and complements NVR.

NVR is a strategic model, and a key strategy is joining with the parents in identifying the main behaviours that they would like their child to stop. We rank them in importance so that the two most severe behaviours are tackled first, putting the others aside until later ('basket' exercise), like goal setting, a common systemic family therapy tool. We start at the position where people are asking for help, without looking into the past, which is similar to solution-focused therapy. It could be argued NVR starts from a first-order position by prescribing strategies to tackle the prioritised behaviour, for example how to de-escalate a situation. However, quickly the carer notices that when they act differently towards the child, they feel better about themselves as people. Once this space is created, they are more likely to be curious about what the child is communicating through their behaviour. The parent begins to cultivate compassion for themself and develops empathy for their child, moving towards second-order change.

In systemic therapy, we collaborate with families in many ways: narrative therapy (White & Epston, 1990) developed 'outsider witnessing practices' and the Just Therapy Team invited previous clients as outsider witnesses or consultants to their practice. NVR in the UK has expanded on this idea by embracing 'parent participation' (Heismann *et al*., 2020): 'graduate' parents offering guidance, support and empathy from their position in most NVR groups. Many parents later trained as NVR practitioners and now deliver groups on their own. Parents also presented at national and international conferences and co-authored books. Parents, from their position of lived experience, are in a unique position to contribute to the expanding NVR practice field.

Families' and carers' potential to be creative and navigate their way through what might seem insurmountable difficulties are unlimited. The essence of NVR practice was captured by one parent as *"a new vision of relationships"*.

Violence can be understood as those social and political practices that are leading to systemic, structural and individual forms of destruction and life negation, which can take the form of power abuses, social control, social injustice, inequality and unemployment. These destructive practices lead to the annihilation and breakdown of community cohesion, social relations and family life.

Non-violent practices (based on the ideas and philosophies and activisms of Gandhi, King and others) include the naming, de-constructing and dismantling of negative and de-humanising influences, reducing their impact on the health and mental health of individuals and whole communities.

In Gandhi's words: *"Truth is the end, and nonviolence is the means"*.

In the '60s the civil rights movement put the frustration of unheard voices and silent stories on the agenda to challenge injustice.

Martin Luther King emphasised the need to experience the anger, whilst not allowing it to weaken the truth of actions.

Showcasing lived experiences was a shift away from abstract knowledge to concrete experience and narrative, illuminating an alternative way of sense-making, which privileged embodied, environmental and everyday experiences to help the understanding of the social world. It brought awareness of the degree to which human and non-human interactions are implicated in the reproduction of social power, as a way to support change in the relational fabric of human lives.

Obama's mantra *"stronger together"* was a recognition that people have to come together to support families and their communities in finding ways of disengaging with oppressive structures and practices.

In line with Gandhi's, King's, Mandela's and Obama's philosophical and political ideas and activism, peace and nonviolence are vital to ensure the endurance of the human race.

Judith Butler (2020, p. 10) asks, *"How can NVR act as an antidote to these precarious influences of violence and contribute to social change, where these various acts of violence are 'checked or ameliorated'"*.

There is no quick or neat response to this question. Nonviolence had an impact across history and continues to have the same effect today, as a method of protest and activism to work towards a more equitable and just society.

Most recently, social media has brought into the spotlight injustices that have existed for centuries, creating global activism as, for example, in relation to the murder of George Floyd and the rigged elections in Belarus, and in the reaction to environmental destruction. NVR is a powerful tool to bring about worldwide social, political and economic justice and equality.

> ***"It doesn't matter how strong your opinions are. If you don't use your power for positive change, you are, indeed, part of the problem"*** (Coretta Scott King)

In living daily practice of NVR, the principles and strategies of the approach remain uppermost in our thoughts and actions. NVR UK has strengthened our involvement: seeing things from a family therapy and other professional points of view has enabled us to reinforce our own skills and impart them to struggling parents in groups and individual settings.

Our key interest is disseminating the approach to as many families, schools and communities as possible, because we know that it works on many levels: with children, work colleagues, teachers, the police and prison service. Our own lived experience evidences that, in most situations, a peaceful, non-combative approach is key to positive outcomes. Building and rebuilding relationships is vital for achieving preferred behaviour(s) and for modelling expected behavioural norms.

Over recent years, many people have testified that things can and do improve with persistence and a robust support network.

Educating parents and carers is crucial. It would be beneficial if more educators, social workers and other professionals involved with young people who display challenging behaviours were trained in NVR.

- School staff could learn that extreme behaviours can be de-escalated in a calm way
- Parents and carers could accept schools as an extension of care around their children
- Blame and judgement could be avoided on either side, while collaboration could be promoted to try and find the root of the behaviour(s)
- Support could be identified and targeted early
- Violent and controlling behaviours in the classroom could be reduced.

Sanctions, exclusions and punishments do not stop violent and controlling behaviour. *"An eye for an eye only ends up making the whole world blind"* (Gandhi).

Lily, 17, said:

> *When I was a teenager, I would often resort to violent behaviour towards my mother, who would react 'like for like'. All this did was escalate the situation and lead to our relationship being completely broken down. When my mother was offered a place on an NVR group, things slowly started to change and improve. We were able to rebuild our relationship and things at home became much calmer. Not only did this help me deal with my own issues, it also gave my mother support at a time when she felt completely helpless.*

NVR UK; Past, present and future: Reflections

With the current pandemic, life has changed significantly. As a result, the mental health of many has been severely impacted.

We believe NVR can help prevent harm to individuals, families and communities. In addition to education, we want to focus on early intervention in adoption and fostering, county lines and the digital world.

The practice has developed hugely in the last decade. The national conference (2019) and AGM (2020) highlighted the need to unite and work together with other regional networks. Remote working and virtual NVR practices can facilitate this. As NVR has evolved and become more widespread, NVR UK has become a vital forum for sharing knowledge and good practice, for reviewing and consolidating policies, processes and training programmes, including training of supervisors and trainers.

The crucial aspect of parent participation also continues to move forward in an exciting way: parent practitioners are further developing the collaborative involvement of parents on all levels of our NVR UK work.

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Aimi Willmer is an NVR UK accredited parent practitioner for NVR South (admin@nvrsouth.org) as well as secretary/admin for NVR UK.

Michelle McCarthy, having struggled with her own child's extreme behaviour, has gone on to train as an NVR parent practitioner and is proud to now be a part of NVR UK.

Elisabeth Heismann is a systemic therapist, supervisor, co-director of NVR Action and Practice, co-editor of *Non-Violent Resistance. Innovations in Practice* and co-author of *Whose Tune are we Dancing to Anyway?*

Liz Day is a systemic psychotherapist, supervisor and consultant in private practice (www.graigconsulting.co.uk). She is deputy editor of *Murmurations: Journal or Transformative Systemic Practice*.

Sue Dromey is an integrative child psychotherapist, PAC-UK/Family Action practice manager, NVR-UK practitioner, and runs NVR groups for adoptive parents/special guardians. Sue's trauma work with children and parents combines with NVR principles and practice.

Denise Wilson is a systemic psychotherapist, teacher, trainer and supervisor. She trained in NVR in 2008, and in 2016 set up an independent NVR training and consultancy practice, NVR Innovations. Contact: denise@nvrinnovations.com

Julia Jude, is a systemic psychotherapist, group psychotherapist, supervisor, visiting lecturer, co-editor of *Non-violent Resistance: Innovations in Practice* and co-director of NVR Action and Practice CIC: http://nvrtraining.org

Dawn Oliver is an NVR-accredited practitioner, supervisor and parent expert-by-experience. Dawn is based in London and is a director of NVR Practitioners Consortium CIC (http://nvrtraining.org/).

Margaret Smith has been practising NVR since 2008 in a multi-agency team in Southampton, and training NVR practitioners since 2014. She is co-partner with Denise of NVR Innovations. With a background in education, Margaret is particularly interested in NVR in school settings.

'Dysgu' – teaching, learning and embodying NVR

Kiran Flynn and Ann Jones

'Dysgu' is the Welsh word meaning both 'teaching' and 'learning'. It represents the reflexive process between the two: you cannot teach without learning, nor learn without teaching. When we met the Eltayeb family*, we put 'Dysgu' into practice.

We, Kiran and Ann, are both family therapists working in a local authority children's services department. We hold different racial and cultural identities and are at different life-cycle stages. We worked with the Eltayeb family for six months. Their two sons – Rayan, aged 11, and Jamal, aged 8 – were in local authority care, as there were worries that the parents were using unreasonable physical force to discipline them. The Eltayeb parents were born in North Africa, but their sons were born in London.

We provided separate sessions for Rayan and Jamal, whilst also using NVR with the parents, to encourage them to think about managing behaviour differently. Rayan expressed his worries and fears through violent escalations and running away, which his parents struggled to manage without using physical discipline. Much of NVR teaching and practice asks a parent or carer to notice what is 'going on', both within their bodies and in between bodies in communication patterns. In this way, parents and carers create the possibility to 'anchor' themselves by regulating their bodily responses, and preventing escalations (Omer, 2004, p. 49). NVR encourages parents to support children in doing the same. In 'anchoring' themselves, parents and carers can 'anchor' their children, so their children feel safe and contained.

> **In 'anchoring' themselves, parents and carers can 'anchor' their children, so their children feel safe and contained.**

We suggest that talking about embodied experience can be a way of connecting with families and practitioners across different cultures. Vall *et al.* (2018) suggest that when therapists and clients focus on embodied responses, it gleans new possibilities for *"the individual's relationship with others"* (p. S58). We will now show how sharing our embodied experience of an escalation in therapy helped us join with the Eltayab parents, and develop new possibilities.

Ann noted a concrete but implicit feeling, later symbolised as growing dread, in her body when, during a session with the children, Rayan challenged a boundary set by Kiran. Both Kiran and Ann were adopting a parental presence stance. Noting the growing dread as a tangible discomfort in her body, Ann was about to distract Rayan, when, without warning, Rayan angrily threw a toy at Kiran and Jamal. Kiran noted her feelings of annoyance at being struck, but took a deep breath, remembering the importance of holding parental presence. Rayan suddenly fled the therapy room.

We were both aware of the need to regulate our emotions and to maintain a parental-presence stance, whilst also aware of the potential risk and danger to Rayan. Our offices, shared with a public library, are situated on a busy A-road in London. Rayan could easily exit the building into the bustling street.

Ann's dread had now developed into a state of fear: heart pounding, stomach

discomfort. Agreeing, in the moment, a unified containing response to both children, we agreed Kiran would stay with Jamal, whilst Ann followed Rayan. Fortunately, Rayan chose to run into the library, not into the busy street. Ann breathed a sigh of relief. Now that Ann knew Rayan was safe, Ann also felt safe. Kiran, not yet knowing this, continued to practice ways of calming herself down, in order to be present for Jamal and able to reassure him as he asked questions about his brother's wellbeing.

Ann stood by the only door that allows entry into and exit from the building. Standing there, she was able to appreciate the benefit of time. She could feel her body gradually relaxing, letting go of her fear and anxiety. She now had time to appreciate others around her, busily getting on with their day, oblivious to her experience. This brought perspective and time to think. Both Ann and Kiran experienced the gift of pressing 'pause': the benefit of delayed response. After a period of about five minutes (which felt much longer to Kiran and Ann), Rayan exited the Library to look for us. Modelling a unified response, Ann and Kiran reassured Rayan that we were 'still there for him' and that we were 'not against him'. Kiran explained that we would speak about what happened in our next session – thus allowing the iron to 'cool' (Omer, 2004, p. 52).

Standing there, Ann was able to appreciate the benefit of time. She could feel her body gradually relaxing, letting go of fear and anxiety. She now had time to appreciate others around her, busily getting on with their day, oblivious to her experience. This brought perspective and time to think.

We shared our experience with the parents. We asked how they would have felt and responded to the incident and wondered whether this compared with the way we felt and responded. This served as a process of joining. We too had experienced frustration when Rayan refused to listen. We too had experienced dread as we noticed potential for an escalatory situation. We too had experienced fear for Rayan's safety, and the relief of knowing he was safe.

Throughout, the parents noted that we had also modelled a unified response, and adopted a parental presence stance. The parents also noted the benefit of regulating emotions, as well as the benefit of delayed response. With the parents, we sought an understanding of Rayan's behaviour and addressed the fundamental need to provide containment and reassurance that we were unconditionally 'there' for Rayan and Jamal. From this experience, we both learnt by having insight into the parents' experience. From this experience, we were also able to teach.

Referring to felt experiences in the body served as a medium, a co-constructed language, that strengthened the joining and connecting with the family. Modelling 'Dysgu' in this way and working alongside a dedicated social-work team, the children eventually returned to their parents' care.

*All names and identifying features have been changed.

Ann Jones

Kiran Flynn

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Kiran and Ann are both family therapists, who worked together in a local authority children's services in London.

The differences between traditional parenting and NVR parenting from the viewpoint of different family members

Dawn Oliver, Rachel Braverman and Sophie Doswell

As an NVR parent, Dawn often draws on her own NVR experiences when speaking to other parents, carers and professionals about the differences between NVR and traditional parenting approaches. The atmosphere in her home has improved immeasurably and she has begun to wonder how different members of other families perceive their own NVR journey.

This article reflects the views of one family's lived experience of NVR from the viewpoint of the parents and their children. Rachel conducted interviews with each participating family member separately. Dawn then drew the responses together into this document. All three authors then reviewed and edited the article.

All interviewees have read this article and consented to have their words presented as they are. For reasons of confidentiality, pseudonyms have been used.

About the family and the interviews

The family is of dual heritage (White British mother and Black British father). The parents, Julie and Henry, have four children, the older three are *"home grown"* – 26-year-old son, Jerome, 22-year-old daughter, Jasmine and 19-year-old son, Ash – and one adoptive daughter April who is now 17 years old. They live in a cosmopolitan and leafy suburb of a UK city.

April joined the vibrant family just over 15 years ago. *"She was feisty and fun (and still is!) and, as she is also of dual heritage, fitted in to the family 'look'."* It was not long after her arrival, however, that April's behaviour deteriorated. She became a *"little hedgehog on acid!"*, gorgeous on the inside, but when she felt 'strong feelings' the spikes came out and someone got hurt. Sometimes she hurt herself, sometimes family members and sometimes students and staff in school.

Having successfully parented their three older children, the parents persisted with their usual parenting style – traditional, loving but boundaried, incentivising good behaviour and punishing undesirable behaviours. With encouragement from professionals, family and friends, Julie and Henry persevered with this parenting style for seven years. It did not work for April who responded with 'strong feelings' and behaviours that challenged, such as physical aggression, scratching herself and others, putting herself at risk of harm and screaming. The situation became untenable and almost brought the family to their knees.

Six years ago, Julie and Henry encountered NVR – the 'non-violent resistance parenting approach' … and *"the rest is history"*.

All members of the family were invited to participate. The older son, Jerome, declined to take part. Family members were interviewed individually, by telephone, with broadly the same format. The questions focused on parenting styles, resulting changes in young people's behaviours, relationships between family members, with an opportunity to add anything else they wanted to say. The interviews lasted 20 to 30 minutes each and were recorded and transcribed.

Themes:

1. Change

Both Henry and Julie believe they have dramatically altered their parenting styles over the last few years. Henry reflected, *"It was quite difficult to apply"* the principles. However, only one of the children, 22-year-old Jasmine, concretely noticed a change: *"I definitely felt a shift in their parenting styles"* and *"as we got older, their parenting style became more like trying to get to understand in a different way how we were in the wrong or how we had to change"*. April, the youngest, also said she had noticed a change but felt *"like it's been more gradual"* and didn't *"think I've noticed it drastically"*.

2. Shouting versus calm

One key action both parents report working hard on, is not *"putting fuel onto the fire and making it worse,"* and not *"matching […] anger with being angry"*. It is noteworthy that without exception, all three children commented on how much calmer their parents appear in recent years. Ash now experiences Julie as *"less angry, less shouty"* and he prefers when his parents are not shouting because *"when they start shouting, it can escalate the situation"*. April also said *"I don't think they shout anymore"* although also stated her father *"has a very, very loud voice. It booms through the house"*. Ash, in contrast, still believes his father *"does shout quite a lot,"* and it *"puts me in a mood"*. Jasmine revealed that "[at home] *it's a lot more calm and relaxed"*.

3. Outcomes of calmer home

As mentioned above, the effects of Henry and Julie implementing the NVR

principles with their family, notably de-escalation, has impacted each of the 'children' differently. Jasmine feels she is *"not worried about what my parents' reactions are going to be"*. She commented *"it was definitely a positive thing for my relationship with my parents because they spoke to me with respect, which made me in my turn respect them more"*. April noticed her parents demonstrating an increasing amount of understanding of her actions and feelings which is helpful.

4. Punishments

Having worked very hard to move away from a more traditional 'rewards and consequences' parenting style, Julie was somewhat disconcerted that only April mentioned this change. She asserted *"punishments didn't work"* and that *"little kids aren't going to learn by you telling them off. They need to learn themselves"*. April shared that by allowing her to make and address her own mistakes, it helped her learn from them.

5. Change in April's violence

Henry found *"learning to prioritise what's really important"* via the 'baskets' principle was extremely useful. The first priority behaviour was April's violence and as April herself acknowledged, she is no longer violent. April believes *"that comes with maturity and the way my parents have parented me. They treat me like an adult"*. The parents do not think this is strictly true, but they do actively increase their 'parental presence' with April, listen attentively to her verbal and nonverbal communications and respond using the 'communication model' when appropriate whilst taking into account her perspective and needs.

Ash saw a change in April's behaviour: *"In the last few years, there's been a big improvement in her behaviour. Maybe that has been different because of my parents' parenting"*.

Jasmine has also *"definitely noticed that now she* [April] *doesn't have tantrums in the same way she did when she was a kid they* [the tantrums] *were a lot shorter and a lot more controlled as a result, I think"*.

6. Announcement

April was specifically questioned about the two NVR Announcements Julie and Henry have delivered. She acknowledged her parents had *"done that a couple of times"* and found it *"a bit upsetting because I didn't think my behaviour affected them"*. As a result, she *"was more conscious and aware my 'lash outs' were less because I was keeping it in and I didn't want to upset them"*.

7. Relationships with April

Since April has reduced her 'lashing out', having tantrums and meltdowns, Ash recognised that his relationship with his youngest sister has *"improved recently, is improving"*. Previously, *"the way she'd shout or be rude to my parents negatively affected my relationship with her"*. Jasmine also observed a change in her relationship with her sister *"in a positive way, because as a result, I wasn't seeing my parents as stressed which then made me less resentful to her. There were still always ups and downs. It was never perfect, but definitely a big impact"*.

8. NVR is not a quick fix

An open question at the end of the interview resulted in Jasmine speaking about NVR and how *"it's definitely not a quick thing. It's something that needs to be worked on. It can't just be one adult or parent or guardian that's doing it. It has to be everyone, otherwise that child is going to feel very confused and not going to behave"*. Consistency, for this young person appears to be key; this idea fits very well with what we as NVR practitioners teach parents, carers and professionals when embarking on their NVR journey.

Conclusion

Exploring the differences between traditional and NVR parenting from the viewpoint of different members within a family has been illuminating and extremely useful. Clearly all three children noticed their parents' intentions to stay calm and appreciate the positive changes that have resulted from these endeavours, namely a reduction in April's difficult outbursts and improved family harmony. Both daughters believe some of these improvements are down to maturation. Whilst maturation has played a part, without Julie and Henry making important changes to their parenting style by adopting each and every NVR principle to the fullest, they would not be seeing such significant changes to either their family dynamic or April's life prospects.

All three authors are directors of NVR Practitioners Consortium CIC:

Dawn Oliver (lead). Please see page 41 for Dawn's biography.

Rachel Braverman (interviewer) is an NVR-informed practitioner and parent expert by experience.

Sophie Doswell is a clinical psychologist and NVR-accredited practitioner (collaborator).

Creative use of personalised interventive interviewing reflexive questions

TK Vincent

What is the article about? Sharing good practice in respect to creatively engaging young people, particularly those on the autistic spectrum by using their interests as a vehicle for intervention from a position of curiosity.

Introduction

I was thinking about the nature of change and specifically how positive change within families can be supported by professionals. During my reflections, I was reminded of the work of Watzlawick *et al.* (1974) who helped me to differentiate between meaningful long-term change, and ineffectual change that only occurs during pressured compliance. They described "first order change" as change within a structured system using the same set of rules and factors – i.e. superficial and lip-service change. In contrast, "second order change" occurs where creating new rules brought about transformative change (p. 38) – i.e. where beliefs are challenged and self-directed long term change occurs. This in turn was especially useful when identifying and describing strange loops (Pearce, 2004) or double binds (Bateson *et al.*, 1956) that lock behaviour patterns into an unstable repetition. These cycles of harm or pain can only be broken via second order change.

Both Pearce and Cronen's (1980) 'coordinated management of meaning' and Tomm's (1987) 'interventive interviewing reflexive questions' aim to engage people in conversation that encourages self-created second order change. I was particularly interested in exploring how I could engage young people who are disenchanted with the repetitive nature of conversations with most professionals, and particularly those who have been in long-term care, or are on the autistic spectrum. It was hoped that by creating different conversations, not only could I spark interest in talking to me, but also use this as a broader vehicle for intervention.

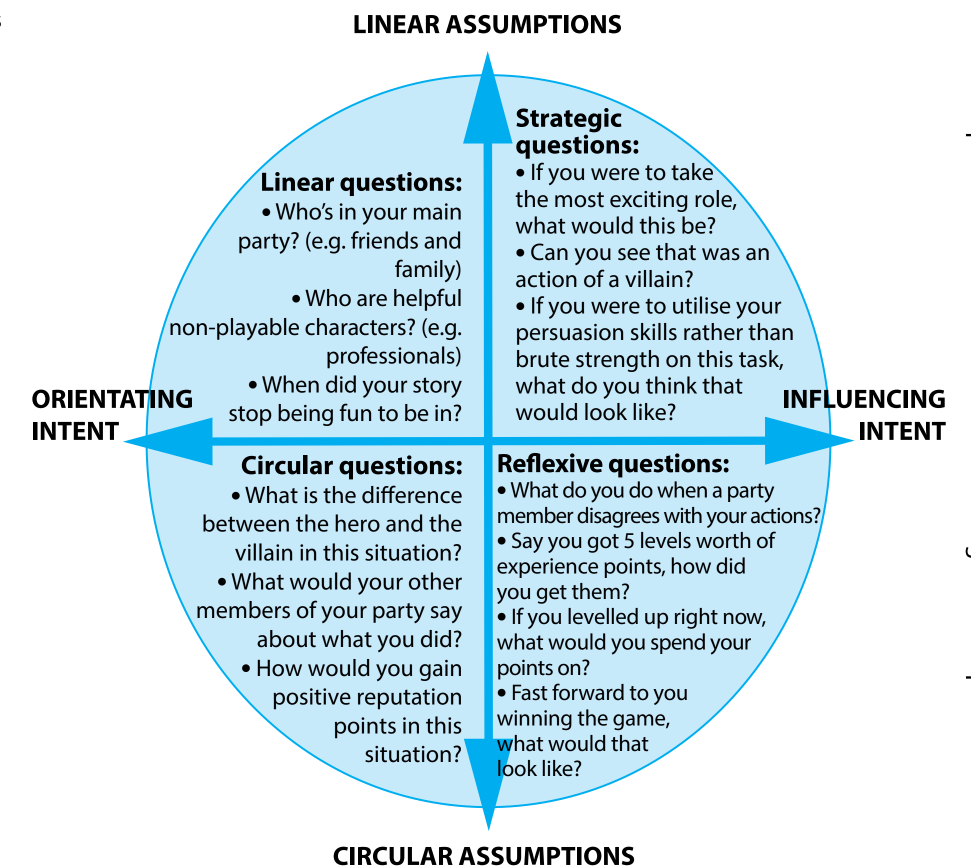
Some client background

I was offering systemic talking support to a British Caucasian family of a 16-year-old adopted teenage-boy, John (name changed for confidentiality). John had a dual diagnosis of autism and ADHD. His parents reported numerous issues but the most lamented was that John spent many hours playing video games. As a fellow gamer, I can see the allure. From an autistic perspective, gaming is predictable, whilst real life is comparatively capricious. Simon believed people with autism often had a passion that could be used as a *"…resource to therapeutic conversation and to the family"* (2004, p. 258). John's parents saw gaming as a negative escapism. I reframed his gaming as an opportunity to bond with him, and a source of socialisation.

Creative engagement

I argue that even when you're engaged in traditional social work or therapeutic tasks, like exploring the person's support network (e.g. when creating genograms or eco-mapping), this can be done through this lens of interests. Therefore, I generated a personalised version of Tomm's (1988) interventive interviewing reflexive questions through the language of gaming:

The linear questions provided a more interesting way to ask the usual



orientating questions about who is important in the life of the client.

Equally, I felt that by using interventive interviewing reflexive questions in this way, it could be a way of encouraging and modelling preferred behaviour. For example, through the lens of gaming, I could encourage comparisons of actions and choices to the character classes to differentiate how outcomes could have been altered if another tactic had been used. For example, a discussion could be had regarding the possible consequences of lying (the dishonesty of a rogue) rather than the compassion and truthfulness (of a paladin). Or a brutish application of barbarian strength over silver-tongued bard-like diplomacy. This could help teenagers cultivate a more thought-through approach, which could have a meaningful impact on self-regulation of risk.

> John actually chose cleric or healer classes in character creation; this indicated an altruistic streak, and someone who preferred to be a team player

This approach can be used more broadly to explore perceptions held by others, and how that might impact on the relationships and interactions. John's mother was convinced John was only ever interested in instant gratification, and she perceived him to be a loner. However, I argued that this wasn't so. If John was so inclined, he would have chosen characters with a simplistic gameplay strategy – usually hitting people or things until the desired result was produced. However, John actually chose cleric or healer classes in character creation; this indicated an altruistic streak, and someone who preferred to be a team player.

Criticisms

This approach does require extensive research or knowledge of the interest to enable authentic nuanced conversation. Time constraints may prevent this from happening, even if the inclination to engage in this manner is there. Ideally, the professional and the client will have an overlapping interest that would allow them to converse in this way more naturally, but this scenario is rare.

Equally, it can backfire if the questioning is perceived to be patronising rather than coming from a place of engaged curiosity. Certainly gaming can be strongly privy to gatekeeping. Fanatic fans' testing of knowledge can feel gruelling! If you fail their test; you may well lose any rapport you had prior to utilising this approach.

Finally, distinguishing the different types of questions for interventive purposes does require practice, and through an interest lens, this might be an added layer of complication on behalf of the questioner.

Conclusion

Regardless of the interest, if we approach a client from a position of curiosity and where their interests lies, we can have more nuanced and useful dialogue. Certainly, I believe that young people want to be seen as individuals, not as a number or a statistic – what more creative way to evidence your intentions than to do this?

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TK is Harrow's family group conference service manager. She is passionate about systemic practice, restorative justice, family group conferences and human-rights based social work.

Twitter account name: TKDoesFGCs

Twitter handle: @TKDoesFGCs

Email: fulcrumfamilyservices@gmail.com

Tributes to Pat Gray

Pat was the longest-serving member of Manchester AFT and when I took over as chair of the branch she took her role of teaching me how to herd cats very seriously! She would always turn up before the end of the meeting, offer to buy drinks and ensure we didn't miss local gossip off the agenda. She also brought rigour and depth to our thinking and we benefitted greatly from her knowledge, her challenges and her kindness.

Pat stayed connected with systemic people all over the country and beyond, always making time for people and being interested in them. She was a gifted teacher and supervisor and a champion for all aspects of anti-discriminatory practice, equality and diversity but especially issues of race, ethnicity and culture. She spoke briefly about racial trauma at the recent online Manchester symposium and she clearly had so much more to contribute.

Pat was a vital, larger-than-life friend and colleague. We will miss her deeply.

Judy Rathbone (chair) on behalf of Manchester AFT branch

Pat and I worked together in the diversity, equality and inclusion committee for several years. Who'd have thought that it could be so full of warmth and laughter, struggling together with questions of power and its abuses! This was thanks to Pat and her ability to be both earnest and light-hearted. She remained steadfast and persistent for justice and fairness across all the different "equalities", and recognising that in this life we were in it together. She was very aware of the irony that trying to do our best in one area might lead to a contradiction somewhere else. She was able to see good intentions, whatever the results. She chaired the committee with dedication while holding down difficult and sometimes unappreciated public-sector jobs and while looking after her increasingly ill and frail father. She continued her service to AFT after he died, when she could have allowed herself to do a bit less. I feel proud not only to have to have worked with Pat, but for her to call me her friend.

Chris Burroughes

It was an enormous shock to learn of the death of my friend Pat Gray. It is going to take me some time to fully process the loss.

Our careers from psychiatric nursing to family therapy followed similar paths. We met at Barnado's in Liverpool during my training and we went on to work together running foundation courses at Merseyside Psychotherapy Institute. We continued to meet for 'continuing professional dinners', exchanging ideas, offering each other support, but primarily having a lot of laughs.

I will seriously miss what Pat uniquely brought to the world. She was wonderfully playful and fun, whilst being an avid defender of truth and justice.

Continuing professional dinners will no longer taste quite so good.

Denis Lee

I first met Pat when she joined our Liverpool Barnardo's Family Therapy Service in 1993. She completed our team of five family therapists and added additional ingredients with her culture, diversity, humour and personality that fitted in well. At the time we were investigating our own relationships with power and race and put on a lot of workshops and teaching events in the area exploring issues of social justice and diversity. I was the youngest and least experienced team-member at this time and learnt so much from everyone there about these matters. I learned about being challenged and having to face up to internalised prejudices that I was unaware of. We were all committed to this and it was a time of rich learning in this and so many other ways. Pat travelled from Manchester every day and so was often late. I blamed this on the distance and the traffic but later learned that Pat was late for most things, if she showed up at all. She would sometimes drive me crazy with her non-committal way of living her life, right to the end when AFT publishing/*Context* meetings required attendance and Pat would always say *"I hope to make it"*. And

then she would usually turn up late, disrupt the meeting with all her bags and stories of her journey, and be a bit of a whirlwind. But all was forgivable and good natured because Pat was so lovely and funny. She made me laugh and she made me think. She taught me a lot, and we would spar about many things from religion to relationships, always respectfully and with lots of laughs. What a terrible shock it was to hear of her death, which still seems unbelievable. I miss Pat, and our *Context* meetings will not be quite the same without her, even if she did usually miss the beginning.

Ged Smith

Máire Stedman, like myself a former member of the AFT-*Context* publishing group, informed me of the recent passing of our colleague and ally Pat Gray.

The *Context* group has in my experience always been peopled by radical, independent-minded free spirits committed to placing systemic theory and practice within wider social and political systems – but in the olden days we were all white.

Belatedly – for it is never timely enough – in the early years of this century, it was resolved to attempt to address this matter. That year the Institute of Family Therapy was hosting, within four months of each other, the African-American family therapists and trainers Nancy Boyd-Franklin (with her husband CL Franklin) and Kenneth Hardy. These names will in all probability be known to every UK-based family therapist as their writings have featured prominently on course reading lists.

(My experience is that many white family therapists have continued to view issues of race, racism and cultural diversity in a defensive way. Whilst Boyd-Franklin's *Black Families in Therapy: A Multisystems Approach* (1989) inevitably has a US focus and is of its time, the chapter entitled 'Therapist's use of self and value conflicts with black families' remains required reading for those who continue to struggle to integrate these areas into their practice. Guided by the ideas in this chapter, I contributed a short article in *Context* from a white practitioner's perspective (Glenn 2003).

Having already booked my place for each of these events, I approached IFT and requested on behalf of *Context*, if I could take five minutes to address the audience to invite non-white participants to consider joining us. IFT agreed to contact each of them.

Alongside Livia Johnson, an African-Caribbean colleague that I worked in the same team as in Lewisham CAMHS, I had previously interviewed Nancy for the October 1999 issue of *Context* that I edited, themed around 'The political and social context of systemic practice'.

I was very hopeful that IFT would gain agreement from Nancy (we had stayed in touch a little since her first IFT-hosted two-day event in 1999) and her husband. Kenneth Hardy also readily agreed.

Ged Smith, long-time member of the group, for many years the deputy editor and now acting editor of *Context* describes how, although one of the main intentions of such events is to raise the levels of practice of white practitioners, often there are less white people present than at other comparable events. However, they also act as a gathering point for the mutual nurturance of black therapists.

Pat was one of the four (so-called) BAME family therapists who joined me for lunch at a nearby Bangladeshi restaurant.

(When I use the term 'so-called BAME', I explain to those I am conversing with that this is because, globally, white people are in a relatively small minority. In my view it is crucial to recognise this – particularly in these conflicted times when a theoretical underpinning of many people's day-to-day ideas is the assertion of the supremacy of western 'Anglo-Saxon' values, rather than overt racism. And also if we are to acknowledge that ultimately we are all citizens of the world).

She committed herself there and then to joining us at *Context*. She remained a part of the group until her completely unexpected death. Such was her commitment that she travelled down from Lancashire to London to attend editorial meetings, either staying overnight or catching a late train back.

Sharon Bond (2020) has recently spoken of how 'black people frequently find themselves in situations where they are alone' and this can mean isolation and the difference can feel all too apparent.

Pat seemed to have the easy ability to become fully involved in the tasks at hand and to manage the company of the group with little, if any, cost to her own sense of self. It no doubt was beneficial that Ged too worked in Liverpool and he and Pat already knew each other. I suspect too that, for Pat, the achievement of this internal and external balance was also greatly enhanced by the recognition that each of the group members had an ongoing commitment to highlighting and opposing, in our own imperfect ways, injustice and inequality.

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Chris Glenn

Pat's funeral took place on 14 May 2021. If you were unable to attend at the time you can still say farewell here: http://charaproduction.com/patricia-leleith-gray-memorial-page/

Narratives of forgiveness: *A tribute to Pat Gray*

(from the webinar *'Trauma – the emotional demands it makes on us as clinicians and the resources we draw on in our systemic practice to support families'* presented by Pat Gray and Gillian Hughes at the Manchester AFT symposium, *'Working with trauma: Building stories of hope and resilience'*), 17 March 2021

Kate Campbell

Background

Momentarily, as I joined the start of the second Manchester AFT trilogy on trauma within my zoom frame, I was transported back to a former time in my life when the power dynamic in a relationship meant I was struggling to feel heard. Alas, one of my take-home points of taking up a strategic part-time position during lockdown, where I proactively took it upon myself to become more useful, thus immerse myself in allyships with the aim for us to find our collective pandemic voices. I was motivated to take my seat at the table by a UK-based respected Jamaican musical artist who has since become a close friend. When asked how they dealt with large stage performance anxiety they simply said in plain patois verse, *"don't be afraid of nobody"* (anonymous) which supported my endeavour to see beyond my own notion of 'vicarious trauma', as our Gambian keynote speaker delivered his own *"narratives of hope, resilience and forgiveness"*.

Appreciation

How often do we take the time to truly appreciate, and indeed celebrate the pioneering work of our contemporary colleagues, before it is too late? Significantly, I honour the community work of consultant systemic psychotherapist Nasima Khanom, founder of the Grenfell Health and Wellbeing CAMHS Service, who is a prime example of people often neglected or erased from our short-term memories. Significantly, only few months ago we celebrated the AFT systemic discussion between Ms. Khanom and John Hills (Hills & Khanom, 2021). This same person pioneered a voluntary coordinated response to community trauma and worked tirelessly to reach out to the families in crisis (Khanom, 2019). At the same time, was it too painful for us to sit with the pain and difficult feelings as Ms. Khanom recollected narratives of being dismissed by fellow passengers who moved seats away from the hijab-wearing Muslim female. Not just ignored, but worse still, by strangers who

Pat with Ncazelo-Ncube Mlilo on Holloway Road, June 2018

Left to right: Judy Worrell, Kate Campbell, Pat Gray and Joanne Ramsey.

walked away because assumptions made about her identity and notions of her belonging were not a good fit. I wondered how much space was given for the audience to acknowledge Ms. Khanom's painful recollections in the moment.

Reflections

As I bring my reflections to a close, I take inspiration from absent friends. Having set out to respond to the webinar about the impact of trauma on clinicians, I find myself paying tribute to Pat Gray, chair of the AFT DEI committee. Indeed, this article had originally been in response to a call for papers for that particular purpose. However, in a momentous change of events, and in the name of transparency, those plans had to be shelved and it seems fitting to say a few words of respect here. In retrospect, I first met Pat Gray at the Brighton AFT conference in 2016. She presented as a larger-than-life social butterfly, and someone who was kind and attentive to others.

I arranged to attend a former employer/ NHS trust's 'tree of life' workshop on the basis I would leave immediately afterwards. Ironically, the late Lennox Thomas, psychotherapist (who I was reunited with after having met him in 1990s during my social work training) along with Imelda McCarthy were keynote speakers at the event. Selflessly, I received the warmest of welcomes because not only I, but also my partner whose Brighton weekend became disrupted by my systemic practitioner enthusiasm for the narrative methodology. We both found ourselves invited and took up Pat Gray's offer to stay for lunch. So, like naughty schoolchildren, we discretely filled our plates took up our places at the back of the room.

Some years later I attended the 'Advanced Tree of Life Training' with the awesome Ncazelo Ncube-Mlilo (2018). Coincidentally, our 'organisational team of life' included Pat Gray. She named our group the 'Hetu Heru' Project. She introduced her interpretation of *"heterarchy; a non-hierarchical structure based on ancient Egyptian hermetic wisdom, notions and values of the 'elder principle'. Essentially, a handing down of traditional knowledge, skills and gifts by service users and communities"* (Gray, 2018).

Significantly, I believe none of us suspected that the 17 March 2021 webinar would be the last time most of us would see Pat Gray. In the post session reflections, she had indicated to me that the loss loved ones over the global pandemic had taken their physical and her emotional toll on the "hostess with the mostest.". Privileged to be left with the closing comments and lived experiences of our guest speaker, a victim of torture, who had through adversity learnt to find his voice. As in Paolo Freire's 'double consciousness', I dream of equal humility, and the sense that one day, I too would reach that 'narrative of forgiveness'. Gone but not forgotten. Rest in peace, Ms. Gray!

Kate Campbell is a systemic psychotherapist.

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Both/and: Relational resilience, traumatic disruption – webinar presented by Gerrilyn Smith at the Manchester AFT symposium, *'Working with trauma: Building stories of hope and resilience'*, 15 March 2021

Kate Campbell

Nurturing our future seedlings through *"Narratives of busyness"*: *In this space we breathe* – a tribute to Khadijah Saye

Background

This piece is a reflection of Gerrilyn Smith, Canadian systemic psychotherapist and keynote speaker's *'Both/and: Relational resilience, traumatic disruption'* Manchester AFT webinar held on 15 March 2021. As a black female, lockdown had left me, and I am sure many of my colleagues, at times somewhat daunted as we were invited into the expert position, as we engaged in multiple trainings on BAME health inequalities. Even when my body was weighed down with the burden of these extra unpaid responsibilities, either put upon me and/or put upon myself, having been in two minds about whether to attend the first in the trauma webinar trilogy, my curiosity got the better of me. Ironically, I found myself pleasantly surprised as I took up my place amongst the participants, as we learnt messages of how to *"nurture our seedlings"* through *"narratives of busyness"* (Smith, 2021).

Shortly into the webinar, we were directed toward the *"powerfully-evocative silk-screen print exhibition of the late artist Khadijah Saye"* (1992–2017); aptly named *"In this space we breathe"*. This references the work of the late Gambian-British Muslim female artist who was tragically taken too soon in the 2017 Grenfell fire tragedy. Four years on, the British Library series honours Ms Saye's memory, coincidentally a year after the brutal murder of George Floyd, and 28 years on from that of Stephen Lawrence in South East London; each one a demonstration of 'how trauma is embodied in the black experience'.

This article coincides with the first anniversary of the UK's national lockdown. In February 2020, most of us were unfamiliar with the true extent of the impact a global pandemic would have on restriction on our civil liberties. 15 months on, as I write this piece, we approach 'step 1' of what is now termed 'the new normal'.

The first Manchester AFT webinar of a 2021 trilogy saw a coming together of systemic family psychotherapists under the umbrella-term of trauma-informed systemic practice. Firstly, a word of caution about the overuse of traumatic life-scripts in family therapy. Secondly, recipes for bountiful fruit and vegetable harvests where utmost attention to detail throughout the growing season leads to us being rewarded with the fruits of our labour. Thirdly, as most keen gardeners will be only too aware, the fragility of life. Significantly, the pre-planting stage, involves daily preparing, watering, clipping, weaning, pruning and tending our crop, and nurturing our seeds with tender loving care. It is also necessary for us to commit to the long haul. Failure to do so could result in premature death or the untimely demise of our crops.

Sadly, one year ago as an enthusiastic novice, I was over-zealous when I planted my tomatoes, chilli plants and courgettes during the first lockdown. It was actually a source of comfort watching them accompany me to the relentless zoom meetings with young people, families and colleagues. I became so pre-occupied with celebrating the short-term success of growth spurts in my indoor garden, by the time I proceeded to plant them out, I was guilty of neglect and watched them perish in the frost outdoors. In the gardener's world a struggling plant is a metaphor for a stressful environment. Therefore, having replanted cherry tomatoes and chillies I hope to learn from my mistakes in order to replicate the green fingers of my mother and mother- in-law respectively. Perhaps as I watch the seeds metamorphose into the next stage of their journey, my dream of bumper harvests can become a reality.

In 2020, only the slightly more expensive and carefully selected tubers

from Gardener's World's very own Sarah Raven's collection flourished into the brightly-coloured red, yellow and orange dahlias they deserved to become. Now, I have a *laissez-faire* attitude and am quietly confident and encouraged by her slogan *"it's not too late for dazzling dahlias"* this time round. We all need some degree of hopeful displays to look forward to at what has been the end of a long and arduous year during the pandemic.

In an age of zoom fatigue, I started to connect with my own 'narrative of busyness' (Smith, 2021), as I questioned the rationale for making the decision to attend yet another webinar. Already struggling to navigate work-life balance, alongside meaningful self-care! Both of Smith's messages contained infectious humour and appeared to transport me back to memories of a late paternal aunt, who sadly passed away five years ago. The latter had a wonderful phrase that stays with me even to this day. In one of our last meetings, as part of the "girls on tour" female-only mini-break, with entourage of my mum, my sister and me, she concealed her long-term cancer diagnosis. Significantly, she routinely shared anecdotes (with a great sense of humour) including *"…the thing is Kate, you can have too much of a good thing….".*

Both Auntie and Ms Smith had ways where in the moment they could elicit unique pearls of wisdom. Each capable of bringing me into a fit of hysterical laughter. During the first 10 minutes of the training session, I settled in for a 'trauma' masterclass. That said, we were reminded to use the word lightly, in a world where multiple therapeutic interventions claim to offer expertise in the delivery and management of trauma presentations. Having set the scene, Smith skilfully navigated the *"unmasking of our trauma"* with reference to Frantz Fanon's *Black Skin White Masks* (Fanon, 1986).

Reflections

In this piece I attempt to link relational trauma with Smith's (2021) 'politics of death'. As I picture a moose from her native Canada, to be a reflection of a duality of roles in which we are positioned as observer and observed. Currently, a growing 'surveillance culture' coincides with legislation where human-rights vigils and 'kill-the-bill' protests are increasingly frowned upon and even prohibited. As I reflect on the highs and lows of the past 12 months of BLM agenda pre- and post-global-pandemic, racial wounding and other marginalising narratives leave us mourning the loss of loved-ones, friends and colleagues; changing family dynamics, work and life scripts, in our unmasking of the pandemic narratives (Fanon, 1986) we should ask ourselves, what gets left behind in the tidal wash left on the beach. Perhaps the hidden message behind the masks is for us to remember to be more attentive, to nurture our next crop of seedlings, and less othering to struggling marginalised voices in their time of need.

Coincidentally, the webinar makes connections between the loss of Sarah Everard, and the bright, young late Muslim Khadijah Saye, as fitting examples of fragile young females who were taken from us way too young, striking resonances with the words of trainee family therapy students, who bring untold shy stories about their children's commitment to BLM and Extinction Rebellion agendas (Pearce, 2007). Collectively, we share hopeful discourse (Weingarten, 2007) about the next generation who care deeply about the prospect of creating a better social world (Pearce, 2007). Hence, I am eternally grateful for the invitation by the renowned Senegalese Master Djembe drummer and teacher Cheikh Diop, to share in his Gambian day celebration performance alongside his dundun performing protege Ousman Camara. A big shout out also goes to Mr Simon Rowe, from Bunow for taking time to maintain my mental wellbeing, and those of many of my NHS colleagues, by keeping a beat to the rhythm during the two lockdown periods. Essentially, my note to self is to make it a priority to check in with my own self-care, so the take home message will be to attend the British Library tribute to find space to breathe in my repertoire of busyness. Hence, a note to self in the post Gambian Independence Day period will be to visit the photographic exhibition, where we can reflect and future seedlings can be sown, in order to honour the work of the late, great Khadijah Saye!

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AFT webinar series: *A couple in transition: The ultimate challenge?* – a webinar by Ruth Yudkin and experienced experts, 26 February 2021

Emma Balogun

26 February 2021 marked a much-welcomed first-time webinar from AFT that included experienced experts. Psychotherapist, Ruth Yudkin, presented her work with a couple where one partner was transitioning from male to female. The webinar explored the connections and differences between the work of Ruth with a gender-transitioning couple. What was unique about this was the couple in transition were part of a reflecting-team approach, following Ruth's recollection of their time in therapy together. Central to the therapeutic work was the developing identity of the couple, individually and collaboratively. It demanded that they both continually reassess their understanding not only of themselves as individuals, but also of their roles concerning each other and to the multiple systems within which they each operated. Other less dominant stories were also a vital part of the therapy. Both the couple and Ruth offered great transparency and acknowledged that giving the gender transition its full due, but not losing sight of the meaning and value of other transitions, was a challenge for them all. We heard about the questions of identity, difference and transition which arose for the couple. This developed into the dialogue about their experience of negotiating and renegotiating the expectations of their relationship, which was at the heart of work with Ruth.

The webinar exceeded my expectations. I had imagined a couple being part of a panel and perhaps didn't picture how they could be part of such a large web-based forum and still maintain their desired level of power and choice. I wondered how they might navigate around undesired and unexpected questions. I can appreciatively say that the couple was able to pose with a great level of autonomy and selection of what they wished to reflect on. I was delighted that the couple themselves agreed to participate as a reflecting team. This was particularly fundamental, given I am a family and systemic psychotherapist in training with IFT and I form part of a reflecting team in an NHS CAMHS family therapy clinic. To be on the other side and see families offer reflections truly reinforced the usefulness, relevance, and timeless way of practicing with Tom Andersen's 1980s reflecting teams as an alternative to the Milan-style team. It seems relevant to mention here, an acknowledgment of my bias, that is my admiration and appreciation for the work of the late Fran Hedges and Monica McGoldrick. I was pleasantly surprised to experience the incorporation of theoretical reference in such a client-focused webinar.

Following the webinar, I shared my experience with my clinical supervisor, who was also in attendance – yes, this was truly a popular and well-turned-out event. I took away new ideas and ways of thinking, being and practicing. I particularly enjoyed the discussion regarding the couples' transition at the different stages and the meanings this had from their perspectives, including that of their children and grandchildren. It was reaffirming to hear Ruth talk about the use of *"the self of the therapist"* and ideas of *"neutrality"* and usefulness in the *"not-knowing as a position"*, given what we heard about both individuals who wanted different things at different points. The couple mentioned that Ruth asked the *"crucial questions at the critical moments"* which helped them think and talk outside of therapy (sometimes over lunch for two hours, which made me smile, given our role as the therapist, in part, is being able to encourage communication in daily living outside of therapy). I was left with the thought and now application to practice, that when it's time to transition in most given situations, it is crucial for us to custom design a new way of being in relationships. Together it is possible to design what works for you and "us". It could be anything from what enables mindfully creating new ways of relating to others or letting go of past pain that will impact future relationships. From a position of self-reflexivity, my goal is to be reminded that in practice, so much of the struggles during gender transitions are similar to our shared experiences.

The format was a first for me, given the couple were part of a reflecting team, and questions were chosen from the comments section not directly from attendees verbally. This was an additional attraction for me and seemed fitting for the couple given the large attendance. Furthermore, one of the couple's admissions that the experience of talking in the webinar was initially not a comfortable process, although she saw the benefit for others in sharing her experience. There was ample time for questions, both for Ruth and the couple. I want to thank both the experienced expert couple and Ruth, unreservedly, for the wealth and depth of learning offered through their lived experience. I welcome and hope for further AFT webinars with a similar format and inclusion of families in the future, especially in our new world of online therapy. I will continually be appreciative for this webinar, a couple in transition provided us with the opportunity to hear about the lived second-order cybernetics, from a therapist working with a couple experiencing a gender transition within a committed and enduring relationship.

Emma Balogun is a MSc trainee family and systemic psychotherapist at the Institute of Family Therapy and is based in a CAMHS Family Therapy Clinic with West London NHS Trust.

The AFT ethics committee

The idea for this article emerged during one of the AFT ethics committee meetings in late 2020, where, after a year full of ethical dilemmas, we wondered how we might entice more members of the association to join the committee. We decided to write about the role of the committee but also share our stories as committee members. It is our hope that by reading the below, you may reflect on your own ethical practice and perhaps consider joining the committee.

It has been written that *"therapeutic practice must be, above all, ethical"* (McNamee, 2015). But what do we consider to be ethical in therapeutic practice? The *Oxford Dictionary* definition of ethics is *"moral principles that control or influence a person's behaviour"*. But arguing that what is viewed as 'ethical' or 'moral' can be socially constructed. How do we account for this in a world of multiplicity, difference and complexity?

For those of us who practice as registered systemic and family psychotherapists with the Association for Family Therapy (AFT) there is the *'Code of Ethics and Practice'* to help guide our practice. This document helps orientate clinicians when faced with ethical dilemmas, with the ultimate aim of 'doing good' and causing the 'least harm'.

Sitting behind the *Code of Ethics and Practice* is a team of volunteers who form the ethics committee. Members of the committee do not position themselves as 'ethical experts' merely a collective group of clinicians with an interest in this area. The ethics committee works within AFT to assist in the promoting of high ethical standards throughout all levels of the organisation (*Ethics Committee Terms of Reference*, 2020).

For those members who require a space to think and reflect on ethical dilemmas above that offered within the supervisory relationship, the ethics committee can provide a consultation service. The committee is not positioned to offer an opinion on whether a clinician has acted ethically but is able to help map factors that affect ethical practice and offer a multiplicity of perspectives and ideas.

Formed in 1990, the AFT ethics committee has supported many members in their ethical endeavours, from negotiating dilemmas relating to record keeping, the use of job titles, mapping the personal and professional domains and reflecting on therapist core values and beliefs and how they impact therapy. Whilst there have been some similarities in issues brought to the committee, no dilemma is the same and the breadth of enquiries is both interesting and varied. Over the last year we have debated the ethics of remote working, AFT's political positions, offered advice on the complaints procedures and revised the *Code of Ethics* based on members' feedback.

For this article we invited members of the committee to comment on their experience of being in the committee and reasons they signed up.

Tarryn Klotnick – committee member

I joined the AFT ethics committee in the summer of the pandemic; six months after starting to work as a systemic and family psychotherapist in paediatrics. I was curious about who makes up such a committee and how does one become 'qualified' / 'expert' enough to be on the ethics committee? Through this enquiry and to my relief, this committee is made up of 'ordinary' family therapists! I have learned a lot in the almost one year since I joined the committee and hope to continue to be able to do so. It is certainly a process of mutual influence and whilst I offer my perspective on dilemmas that we are presented with, I am really enjoying the learning that comes with the opportunities to respond to and consider the *Code of Ethics and Practice*.

Daniel North – committee member and acting chair

"If eyesight blurs find a railing to follow" (Rumi).

I am a relatively new member of the team, joining the committee in July 2020. The word 'ethics' is I understand is derived from the Greek meaning *"relating to one's character"*. It would appear that it is important to consider the trajectory of our own character development and the context in which it emerged.

In my own reflexive/reflective practice I continue to develop an awareness of the significance of the formative experiences and context of my early life that has led to my current interest and positioning on the subject of values, morals and their application through our professional code of ethics. Our sense of values and morals develop in the interplay between character and the social medium in which our personalities develop.

I have strong memories of my Irish maternal grandfather (John) who held strong views on issues of social justice and class equality that shaped his value base and moral stance.

One of the 'untold stories' which remained a closely-guarded secret within my maternal line for over 70 years, and emerging just before John's death, relates to a subjugated narrative of maternal abandonment, social morality, injustice and shame. His conception, out of wedlock, to a Catholic father and a Protestant mother was deemed unacceptable in the historical period and culture. Commonly, such unions often resulted in discrete adoptions to avoid the 'immorality' and stigma of lone parenthood.

As a child I was very fond of my grandad John's stories of meeting his biological father, joining the army as a 15-year-old runaway, and the many accounts of the injustices he had witnessed against civilians during the early occupation of Germany by the allies. As a young man, John had had contact with the Russian occupying forces and been exposed to socialist ideals. John's working-class roots and the historical narrative of the political and economic oppression of the Irish culture at the start of the 20th century led him to develop a critical stance towards the political discourse of the time. His early formative experiences meant that throughout his life he formed a strong leaning towards the ideals of social justice and political resistance. After his discharge from the military he used his learning to become an electrical engineer in the BBC.

A powerful family story that remained highly influential throughout my life was that of the cost of John adopting and actively expressing certain moral positions. In the UK's politics and institutional culture of the 60s and 70s this resulted in John having to forego the security of his BBC pension for standing by his beliefs and putting his values into action when he assumed the role of a shop steward.

I now understand that from an early age I was being presented with clear ethical models of assuming social responsibility, equity and justice. I believe that John's personal values required a level courage and tenacity regardless of the economic and social consequence. Living true to your values and adopting an ethical/moral stance often comes with a cost. Working as therapists often requires a level of sacrifice for the betterment of those we serve.

As we progress through life the intersections of multiple contexts of family relationships, political challenges, class struggle, community and culture shape our stories , both 'told and untold'. I would argue that we are powerfully guised in our values by previous generations. Their struggles shape our understanding of 'ethical' positions we adopt of our professional lives. As practitioners we are regularly faced with finding a posture of stability, within the constant flux of changing political and economic power dynamics that challenge our practice. Issues such as justice, fairness, equality, fidelity, and beneficence are constantly played out in our personal, cultural and professional lives.

Becoming a member the ethics committee has provided me with the chance to experience some of the wider complexity of human relationships across context and how we adapt to changing power dynamics. The committee has offered me opportunities to assist and provide a 'handrail' to my colleagues by offering a safe and supportive space to reflect and rebalance beliefs and ideas. I have found it a valuable and enriching experience to work alongside such a highly skilled and experienced group of therapists, and recommend this type of service to any members wishing to develop their practice.

Sylvia Metzer – committee member

I first joined the ethics committee about 2.5 years ago after an AFT conference. Since that time I have attended meetings which have been either on the phone or by Zoom. I also attended one face-to-face meeting in central London with the DEI (diversity, equality and inclusion committee), which I found very stimulating. This relatively low level of demand on my time has been important to me as I struggle to manage all my general work and family commitments but means I can be involved in some fascinating aspects of AFT policy. I had been keen to have greater involvement and help develop the profession – my dilemma had been which branch to join. My interest in professional dilemmas and the fact that this group needed more support was an attraction.

In my time with the group I have spoken with family therapists who have faced a wide range of dilemmas, including with supervision, professional practice, grievance and poor conduct situations. I have also worked with issues where there have been delicate ramifications and where I sought the group's views on working confidentially with technology. As a group, we are involved in making recommendations which can impact at AFT board level and are of relevance across the field of systemic therapy.

Lisa Lowndes – committee member

I'm currently a student on the Exeter MSc Systemic Psychotherapy programme working in a local CAMHS team as a trainee family therapist. I joined the AFT ethics committee in my first year on the course. I was interested in joining the ethics committee at a time where there is increasing pressure on services and higher thresholds in accessing these services. As a student, joining the committee was quite a daunting prospect but I have found the group flexible and inclusive of new members. Over the year I have been a member the committee, we have needed to respond and adapt to the changes in the world around us. The group provides a space to consider these through an ethical lens and I have enjoyed being part of these conversations. As I progress to a qualified family therapist I look forward to further contribution so the committee.

Katie Watson – committee member

I am a practising systemic psychotherapist working within the NHS. Considering what makes me an 'ethical' practitioner is an important reflection to my practice (and life). I recognise that my relationship to what is 'ethical' or 'moral' is ever evolving, socially constructed through dialogue and experience.

I joined the ethics committee in January 2020 having known little about the role of the committee beforehand. Over the past 18 months I have appreciated the opportunity to support a number of clinicians with their ethical dilemmas and influence practice at policy level. I was relieved that the committee does not require you to be 'the expert', but recognises the value in offering a multiplicity of thoughts and reflections to dilemmas.

Due to the multiplicity required in ethical debate we are always keen to hear from other people who may be interested in joining the committee.

If you are interested in exploring becoming an ethics committee member please contact the AFT office: mail@aft.org.uk

The Ethics Committee Terms of Reference can be found on the AFT website under About AFT – Who's who – Committees and sub-groups.

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Statement

Hello,

We're a newly formed group of people who were angry and disappointed that the AFT board took down the Black Lives Matter solidarity statement from the AFT website, didn't consult members about this decision before taking this action, didn't tell members and to date has provided inadequate explanations, apologies and ways forward.

A Black family therapist noted that the statement was suddenly absent on the AFT Google Groups email list. This was met with outrage from some therapists and surprise and considerable disquiet from others and was followed by requests to put the statement back up and requests for a more detailed explanation. The AFT board said that there had been "protests" about the statement and that they were now worried that the Charities Commission might see the solidarity statement as too "political". Responses on the AFT list noted that the Charities Commission has a broader view of what is political and this is unlikely to be a problem. Many charities' current statements in solidarity with Black Lives Matter were noted as examples.

We'd like to welcome you to meet with us with the aims of encouraging and pressing AFT to be more active in responding to inequality and abuse of power in the world around us and in our professional organisation. We as AFT members are clear that Black Lives Matter and want our professional organisation to reflect that stance at a time when many Black people (in AFT and outside) continue to be harmed by structural racism and lack of solidarity from White-led organisations.

At the moment we're mainly a white group, so we need to be examining our white privilege and how white supremacy culture shows up in our work. We'd welcome Black family therapists who want to be in the group and hope not to make you do the work of educating us (unless you want to!). We want to find ways to be accountable. We welcome everyone as long as, like us, you're clear (with no avoidant wording) that Black Lives Matter.

If you're interested in these ideas, do email us at ilikehottoast@me.com

Black Lives Matter

The AFT Diversity, Equality and Inclusivity Fund

This fund was established in 2021 following the death of Pat Gray, who was a long-standing and influential member of AFT and the Manchester Association for Family Therapy. This memorial fund aims to honour the work she undertook throughout her career as a systemic therapist, supervisor, teacher, trainer, mentor, colleague and activist. We aim to promote and champion diversity awareness, equal opportunity and inclusion. Pat was passionate, eloquent and dedicated in her commitment to these aims. Her words, following the murder of George Floyd are inspiring:

> ***"Let's strive forward, doing what we can, when we can, not missing opportunities to challenge and encourage each other to 'wake up' and know our full history – black history is part of not separate to all history."***

In supporting these aims this fund will contribute to her legacy by supporting projects that make a difference. This may include improving access to educational opportunity for people from black and minority ethnic communities, or initiatives that give voice to marginalised experiences and expand our knowledge and ability to challenge prejudice and injustice.

AFT branches are invited to apply for up to a £1,000 grant each year by submitting a brief summary or how this would be used. In this first year 2021 the grant will be used by Manchester AFT to support projects in the Northwest. Future applications for the annual grant can be submitted to the AFT office (The application form is available here: https://cdn.ymaws.com/www.aft.org.uk/resource/resmgr/committee_groups_&__minutes_etc/dei/the_aft_diversity_equality_a.pdf) The deadline for 2022 applications is the 1st of November 2021.

If you would like to contribute to the fund this year, donations can be made by bank transfer to: Association for Family Therapy (AFT) Manchester. Sort code 20-64-12, Account Number 30707686. Please use the reference 'diversity'. Thank you in advance for your contribution to the fund, however large or small, in memory of our inspirational, kind, generous and much-loved friend and colleague Pat Gray.

On the 10 December 2021 AFT and MAFT will be co-hosting a Memorial Day Conference in partnership with the Psychological Therapies Training Centre (PTTC) in Manchester, where tributes and stories will be shared in relation to Pat's inspiration, within the annual North West Sparkling Systemic Supervision Conference. The AFT branch recipients of the 2022 AFT Diversity, Equality and Inclusivity fund will also be announced. For details of this event please see the advert on page 58.

AFT news

Hope this newsletter finds you enjoying the early days of summer, possibly planning some nice activities with family and friends, after the long months of lockdown and meeting the demands of work in challenging conditions. For many of us our work volume – although different – has not changed much. This is the same for the cogs and wheels of AFT. It must be noted here – as you are probably aware – that even before the pandemic, organisational demands were considerable.

In this update we want to explain some of the structural changes which are happening and the reasons why. AFT has been described by Amy Urry, acting executive director, as a bungalow which over the years has had many extensions added. In that process the natural flow of the rooms has got a little bit lost. In addition the AFT family has expanded and is now struggling to fit into the bungalow. Something needed to be done.

For a few years now the board has been exploring different options, attempting to introduce improved ways of working; these attempts resulted in varying levels of success. Last summer it was decided that we needed a different pair of lenses to look at the bungalow called AFT. Paul Kennedy helped us to find the Cranfield Trust who provided a free-of-charge strategic review. What follows is an overview of their recommendations following their snapshot assessment of AFT. As so often happens with snapshots there were components of the review where they did not have sufficient understanding and didn't get it quite right, but we know about those and are making the adjustments as we go along. The text below has been taken from the executive summary provided by them.

The summary reminds us of AFT's core functions:

> ***"AFT exists to benefit the public by the promotion, by all available means, of the scientific study, practice, research and teaching of family therapy and systemic practice to bring together those of whatsoever professional discipline who are concerned with the care or treatment of families."***

We asked the Cranfield Trust to provide an external review of AFT's strategic direction in delivering its mission in the future. They looked at our strategic planning, governance and organisational design.

Planning: it was noted that the organisation and staff lacked a shared focus for planning, monitoring and evaluation. Decision making was felt to be slow. In response to this we have re-activated the strategic plan, ensuring it is reviewed at monthly board meetings. In terms of our slow decision-making process, we have invited the committee chairs or deputies to join the board meetings to help with the decision-making process.

Governance: the report described AFT as *"functional for maintaining current activities"* having developed operationally *"with reliance on goodwill and custom and practice"*. As noted in planning, decision making is slow and often 'unpicked and revisited' making strategic changes – needed for good governance – much more difficult to execute. In its recommendation the review advised the appointment of a director responsible for ensuring that decisions are carried out. As AFT has not replaced Reenee Singh, our CEO, who stepped down last December – and responding to the advice – the board asked Amy Urry to take on the role of acting executive director in the interim. This post will be advertised within the near future. It was also stated that although the board has a high level of expertise in the field of family and systemic therapy it lacks expertise in other key areas e.g. legal knowledge, digital development and human-resource management.

Organisational design: this is the area where it is most obvious that our bungalow, built in 1975, is no longer fit for our purposes. Our administrative team – in addition to their specialist roles – deal with many requests from a variety of sources. It was also observed that the digital technology was insufficient *"particularly for the administrative functions of managing various aspects of member relations, data storage, analysis, planning and communication"*. The author of the report recommended that in order to address these shortcomings, as well as to have some expertise in HR management, AFT should look towards developing a new post – Organisational Lead Manager – to plan and manage in-house strategic developments, and provide additional management support to the AFT administrative team. This post is currently advertised.

We hope this gives some clarity to the changes regularly reported; we will of course keep you informed of plans as we review our bungalow and possibilities for renovations or a new build.

with warmest wishes

Erica Widdowson, chair

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Pat Gray Memorial Day Conference

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Sparkling and Poignant Moments within Systemic Supervision

The Greater Manchester Mental Health NHS Foundation Trust Psychological Therapies Training Centre (PTTC) and Manchester AFT (MAFT) are delighted to announce that the 7th North West Day Conference focusing upon Systemic Supervision is dedicated to our colleague and friend Pat Gray who died this year. Pat has been a shining light within the systemic community for decades and has inspired generations of practitioners and trainees, with her passion, rigor, grace, expertise, humility, humour and humanity.

What is it about and who is it for? The day will be an opportunity to share stories illuminating Pat's contributions and influences. We will share poignancy, creativity, successes, or those "light bulb moments" within supervision and training. A tribute to Pat will be followed by a series of short presentations, highlighting individual, retrospective, group, co-working and live team supervision and consultation, including on-line practices. We hope to share and celebrate sparkling or poignant moments of application, innovation, inspiration and motivation, which occur within supervisory relationships and encounters. Systemic supervisors and supervisees, plus colleagues from different disciplines and models are invited to join us. It will be a participatory day and our aim is that people will be able to network, share stories and memories of Pat and leave with a range of supervisory practice skills and positions to adapt and use within their own contexts.

Booking and Cost? This event is funded by PPTC and is free for all participants. Refreshments and lunch are provided. No fees are paid to facilitators and everyone is invited to contribute to the MAFT Pat Gray memorial fund. Pat was a long-standing member of AFT and MAFT. This fund aims to honour the work she undertook throughout her career as a therapist, supervisor, teacher, trainer, mentor and colleague. We will aim to raise and champion diversity awareness, equal opportunity and inclusion. Pat was passionate, eloquent and dedicated in her commitment and the fund will contribute to her legacy by supporting projects in the North West that make a difference. This may include improving access to educational opportunity for people from Black and Minority Ethnic communities, or initiatives that give voice to marginalised experiences and expand our knowledge and ability to challenge prejudice and injustice. Thank you in advance for your contribution, however large or small (The venue cost is £30 per person) in memory of our kind, generous and much loved friend and colleague Pat Gray. You can donate by bank transfer (please use the reference "diversity") to: Association For Family Therapy (AFT) Manchester, Sort code 20-64-12, Account 30707686.

The closing date to book a place is 1st November 2021. The event is likely to be oversubscribed and places are limited and offered on a first come basis, so please book early. CPD Certificates will be provided for all participants. If you would like to consider facilitating a short contribution on the day contact Gary at gary.robinson@gmmh.nhs.uk.

If you would like to book a place email Jo at Joanne.Hewitt@gmmh.nhs.uk

AFT

iapt
Improving Access to Psychological Therapies

BOOKING NOW OPEN
Book your place at www.aftconference.co.uk

AFT Conference 2021 in collaboration with **Friends of KCC** and the **CMM Institute**

Making better social worlds for the 21st century: Legacies and expanding horizons

Thursday 23, Friday 24 and Saturday 25 September – online event

This year, the AFT board are excited to face the challenges of our first online conference through a creative collaboration with Friends of KCC and the Coordinated Management of Meaning Institute (CMMI). Whilst this move to online has been necessitated by the global pandemic, we believe that it brings great opportunities, not least in a theme well known to systemic thinkers; that we are all interconnected and interdependent.

We hope to revisit and reflect on the values, ethics and practices emanating from the KCC school of therapy, consultation, management and research, the great influence of the CMM Institute's theory of communications and the outcomes of their special collaboration over many years. Presenters will also share new developments in systemic constructionist practice (and theory).

Throughout the conference we will be seeking to demonstrate how, by connecting with our roots, we can make a better and more just future for humanity, the natural world and the whole planet. We are seeking to achieve this through a creative, novel, enjoyable and collaborative experience, which draws on the spirit of systemic thinking and a sense of mystery.

Delegate fees:

All-inclusive payment for full access to the 3-day live conference

- £140 Non-member
- £120 Member (AFT, CMMI, FKCC)
- £100 Student rates

Register your place now: www.aftconference.co.uk

Presenters: Taiwo Afuape, Jacob Storch, Sharon Bond, Gail Simon, Kim Pearce, Barbara McKay, Nana Bonsu & Nick Pendry, Tracey Johnston & Peter Robinson, Alastair Pearson & Marit Eikaas, Haavimb & Hossein Kaviani, Vikki Reynolds, John Burnham, Aline Mugisho, Beth Fisher-Yoshida, CMM fellows: Ana Draper, Samantha Thomson, Elisa Marcellino, Susana Carr, Kate Campbell. Please be aware that the speakers may be subject to change if necessitated.

See the conference website for full details www.aftconference.co.uk/schedule

AFT Hull & East Riding afternoon workshop:
1.00-4.30pm, Thursday 22nd July 2021

PLEASE NOTE: DUE TO CURRENT SOCIAL RESTRICTIONS THIS WORKSHOP WILL NOW BE DELIVERED ONLINE VIA MS TEAMS. TO REQUEST AN INVITATION PLEASE USE EMAIL ADDRESS BELOW

Steve Bennett Memorial Workshop

The situation is hopeless but not serious: A guide to structural and strategic family therapy (Don't try this at home)

Facilitator: Dr Gary Robinson

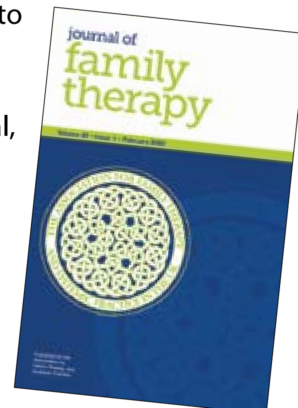
Steve died at the end of 2019 following a long illness, having worked with social services and the NSPCC in Hull for virtually all his career as a social worker and family therapist. As one of the first qualified family therapists in Hull he inspired and influenced a whole generation of social workers, systemic thinkers and practitioners in and around East Yorkshire, including Gary as a supervisor, colleague and friend. This workshop is dedicated to Steve and will feature the ideas and techniques of therapists who inspired him, including Salvador Minuchin, Insoo Kim Berg, Steve de Shazer, Paul Watzlawick and Cloe Madanes.

Gary is a consultant systemic and family therapist and a social worker who has worked with families for 40 years within social care, the voluntary sector, education and the NHS. For the first 15 years working in Hull and East Yorkshire and for the last 25 years in Derbyshire and Manchester. This interactive workshop will include music, stories, skills exercises and case presentations, plus therapeutic practice tools to take away and use in supporting children, adults and older adults. There may be irreverence, laughter, poignancy and tears. The workshop is free, and participants will have an opportunity to donate for the NSPCC if they wish. CPD certificates will be awarded. This event has been rearranged from 2020 due to the virus crisis.

To book your place contact: Andy Stephenson (AFT-HER chairperson) andy.stephenson@nhs.net

New opportunities on the *Journal of Family Therapy* editorial board

As part of a commitment to opening up and making transparent pathways to involvement in the journal, we are advertising and asking for expressions of interest in new positions on the board for two new members and up to four annual internships.



For further details about roles and responsibilities, as well as the qualities, experience and abilities that we are looking for, follow the link below.

https://onlinelibrary.wiley.com/journal/page/14676427/homepage/expressionsofinteresttojoineditorialboard

Call for contributions

Context special issue: *'Ableism and disablism'*

In order to understand disability we need to consider and be curious about ideas of ability. This special issue aims to invite a wide audience to be curious about their relationship with ability and disability. We hope to collate ways in which family therapists explore this in their practice, supervision, training and self-reflexivity. Whilst some family and systemic therapists may specialise in working with people with learning disability; work with disabled people or have lived experience of being 'disabled' themselves, all therapists inhabit/speak from cultural positions in discourse concerning ability, impairment, disability and disabled people. These, of course, intersect with many other aspects of difference.

As guest editors, inviting explorations of ability, disability, ableism and disablism (these later terms highlighting relational processes) we can offer as much, or as little, support as you would like.

If you are interested in contributing please contact either of us on the emails below with your initial ideas: **SystemicVic@gmail.com** and **mark.haydon-laurelut@port.ac.uk**

If you have ideas to share we would love to hear from you.

Please note the following deadlines:

Send an outline of your article ASAP/before 30 November 2021

Guest editors confirm your article has been accepted and word count: December 2021

Interim deadline (submission of draft article): 31 May 2022

Final deadline for articles: 31 July 2022

Issue publication date: April 2023

Call for articles for a special issue:

'Working in medical contexts, working with people with physical health conditions'

We would like to invite articles of up to 3000 words long on the issue of working in medical settings working with people with physical health conditions. We are interested in practice across the lifespan, from working with parents of children identified as having medical difficulties pre-birth to working with people at the end of their lives. We are interested in articles about innovative systemic practices and services, about systemically-influenced supervision and services. We are also interested in self-reflexive pieces where the health of the practitioner resonates in some way with the people with whom they are working. We expect issues of equality, diversity, inclusion and anti-racist practices to be woven in to all articles. If you would like to submit something, please contact us to have a chat. We'd love to hear from people at the start of their writing careers as well as people with greater experience.

jennyaltschuler@gmail.com

sarah.helps1@nhs.net

Please note the following deadlines:

Deadline for article proposals 15 July 2021

Deadline for final article submissions 22 April 2022

PartnershipProjects

Developing new service models in CAMHS, social care and education

Non Violent Resistance Training Programme for 2021

As the first UK training provider to offer a comprehensive NVR course, we have the greatest experience in training professionalsin the UK and abroad.

Note: Where training takes place in person, you can rest assured that all our training venues have been rigorously checked to ensure they comply with the highest levels of hygiene and are Covid-19 compliant and secure

NVR Certificate Course

Foundation and Advanced Level courses available online and in person

The Certificate Course enables participants to develop the core knowledge and skills that are necessary to competently use this intervention for violence, aggression, controlling, destructive and harmful behaviour in the family, school and community.

NVR offers a unique scope and depth of training which ranges from the NVR core model to an integrated approach for working with trauma and with multi-stressed families. After successful completion of the full course (including evaluation), participants will receive the **PartnershipProjects Advanced Certificate in NVR Practice**.

Delivering NVR Parent Groups using the PartnershipProjects Hybrid Format: 2-day module

17 & 18 November 2021

This training module teaches the delivery of parent groups based on the PartnershipProjects Hybrid Parent Group format.

Participants will learn to apply the principles of NVR in a parent group setting, use this environment to improve parents' confidence and utilise group processes to help build their competency in resisting any harmful child behaviour long after the group work has ceased.

Introduction to NVR – Online Workshop

1 day: 14 October 2021

This workshop will give an insight into the underlying principles and philosophy of NVR, and introduce some of its core methods. It will also illustrate the specific child-focused and trauma-focused ways of working with NVR that have been developed by Peter Jakob in the UK.

CPVA Study Day – NEW

PartnershipProjects and Helen Bonnick are excited to co-host an ONLINE study day on **Children to Parent Violence & Abuse (CPVA) – Across the Lifespan**. Drawing together 8 presenters with diverse experiences of this complex issue, morning sessions will focus on scoping the field, while the afternoon explores therapeutic interventions for families experiencing CPVA.

Date: 15 November 2021

Early Bird Price (up to 31st August 2021) – £55

General Admission – £75

Local Supervisor Training in NVR-informed Clinical Supervision – online

23rd, 24th, 25th November 2021

Practitioners require clinical supervision to support them in their work with NVR, so they can maximise their effectiveness and safely manage risk. This can only be delivered safely by professionals who are proficient in the delivery of NVR, and who have received additional training in recognising and addressing the supervisory needs of practitioners working within the approach.

The training develops the skill-base for specific 'clinical' supervision in NVR; this is particularly necessary for workforce development, risk management and safe, competent practice.

Child Sexual Exploitation / Child Sexual Abuse: Non Violent Resistance as a Pro-active Social & Psychological Intervention – Workshop

DAY 1: Child Sexual Exploitation (CSE) and Child Sexual Abuse (CSA) in Families, Residential & Foster Care, with Peter Jakob, Kerry Shoesmith and Erica Castle

In this CPD event, three of the most experienced practitioners of NVR will enable you to explore the application of NVR principles and methods in working with child sexual abuse and exploitation. You will learn how to use the presence-raising and connective methods in NVR and build a supportive community that takes action. The workshop will also feature therapeutic methods to help young people with histories of abuse feel entitled to overcome trauma symptoms and resist.

DAY 2: Child Sexual Exploitation (CSE) and Child Criminal Exploitation (CCE): NVR and New Authority in Education, with Jackie Lindeck and Tony Meehan

In this CPD workshop, we will explore how New Authority and NVR can be applied within educational settings in order to empower staff to reduce risks effectively. By increasing staff and pupil wellbeing and strengthening connections, all members of the school community can experience a sense of belonging that acts as a strong protective factor for those pupils who are being exploited, or who are at risk of exploitation.

NEW training schedule for 2022 will incorporate both ONLINE and FACE-TO-FACE training. This will be listed on our website in September 2021 and published in the October issue of *Context*. Get in touch if you would like to be added to our mailing list to be the first to know!

For more details or to book, please visit www.partnershipprojectsuk.com/training-workshops/ where you will find full details, or email: training@PartnershipProjectsUK.com

The Tavistock and Portman
NHS Foundation Trust

Study at the heart of family therapy with a course at the Tavistock and Portman NHS Foundation Trust.

Enhance your practice with our one year, AFT accredited Family Therapy Supervision course or put your research into action on our Systemic Psychotherapy Integrated Doctorate programme.

Short of time? If you're looking to continue developing your practice, why not take a look at our wide range of short CPD courses, including some in our new Digital Academy, and a 2-day course focusing on working with asylum seekers and refugees?

Join us at our virtual Open Day! Visit us online on Saturday 26 June. Please head to ***tavistockandportman.nhs.uk/training*** and search for Virtual Open Day.

Feel. Connect. Learn.
#mytavi

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Innovation in mind