Peaceful Schools Guidance Leaflet

TACKLING STRESS IN SCHOOLS

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About Dr Venetia Young

Dr Venetia Young trained as a GP in the late 70s in Carlisle. One of her children had a speech and language disorder and another was moderately severely dyslexic and as a result, Dr Young became aware of the workings of the Educational system. In an effort to understand the effects of these problems on family life she trained as a Family Therapist. In this role she worked in Child and Adolescent Mental Health Services (CAMHS), Drug and Alcohol Services and then set up a family therapy service in an adult mental health setting within a multi-disciplinary, psychotherapy department. In this work she learned optimism, about recovery and about the resources and resilience of many of the patients. A solution-focused brief therapy training helped considerably with this. She also learned how services and systems of care can often make people more ill rather than better! She decided to refresh her training as a GP to make things better earlier in the journey of a patient. Working as a partner in a practice in Penrith, she changed systems and perceptions. She often went into schools as an advocate for her patients. Having recently retired as a GP, she has taken on a Safeguarding Lead GP role with the local Clinical Commissioning Group and is working to prevent cases needing active child protection with 10 local practices.

All cases/people mentioned here are real one, but the names and some of the details have been changed to ensure anonymity and confidentiality.

1. Stress in schools

A GP gets a curious view of school life! We see the teachers who are stressed and those who want early retirement on health grounds. We see primary school children who are anxious and want to stay in at break times. We wonder about how many children are affected by bullying and how many are affected by the stress of exhausting school days during which there is no time for quiet rest and reflection. We see adolescents who are stressed at exam times and those that quietly admit they are self-harming to cope with other stresses. We see them for the morning after pill and try to get them to send off tests for Chlamydia. We wonder if they lie when we ask about smoking, drugs and alcohol. We hear about bullying and some extraordinary adult responses to this. We see parents at their 'wits end' with no community support structures and no SEN statements for their children. We know about educational psychologists making reports on children on the basis of money and not need. To us, school seems a jungle containing minefields. Our main point of reference is the school nurse, who we imagine must set off each working day with a metaphorical scythe (to get through red tape lianas) and a mine detector so that she comes out unscathed ready for the next day!

The folk wisdom is that school is just 'a stage of life to be survived'. However it is chastening to look at the impact of school bullying later on in the victim's life. Bullying is very damaging both in the short and long term. Research has shown that most adults with depression and in particular young adults with depression have been bullied. The longer the bullying lasts, the worse the depression rate and the higher the suicide rate.

There can be no doubt that having a peaceful school matters, helping parents to be effective matters and helping teachers to manage their stress matters.

So how can we make schools less stressful for all concerned? What works? I believe that there are three very important things that can make a major contribution to making your school a peaceful school:

- making systems work well together;
- using family trees (genograms) to take a family history;
- solution-focused thinking and questioning.

I believe that if we can weave mindfulness and compassion into all three, then we will have a 'potion' that is highly effective for happiness, resilience and a peaceful school.

2. Working together

A retired headmaster of an EBD school described the systems of care 'Working Together' around children as being reminiscent of an archipelago of services in which the water around the islands were shark-infested. He was puzzled as to why social workers, counsellors, CAMHS and Youth Offending Teams had offices anywhere other than in the schools they served. If you add to this community paediatric nurses, school nurses, community paediatricians, physiotherapists, occupational therapists and speech therapists - there are a lot of professional groups involved in supporting children and young people. One mother of a not-yet-statemented, newly deaf child with other physical health problems, was told by her education support worker that she should have reminded her that the urgent statement for sign language teaching for staff hadn't gone through. The mother's vitriolic reply was that if she had to remind every professional of their duties of care she would have a full-time job as a care coordinator (unpaid) of seventeen professionals! She wished simply to do her job as a mother. The central position of the child and his communication needs seemed to have been forgotten.

Another case occurred when a ten year old girl had stopped going to school for health problems of urinary incontinence and bowel problems. The headmaster of the school had forgotten to inform the school nurse of the sudden drop in her attendance following some distressing news in the family. The family started to badger the GP and the paediatrician for medical input. No one made the connection between the distress and the symptoms. A 'professionals' meeting with the headmaster, school nurse and CAMHS practitioner cleared the air for the school nurse to get involved to smooth a transition into secondary school. Had she been involved earlier a lot of distress and disruption of friendships might have been avoided.

As a rule of thumb, if more than two professional groups are involved with a child, then meetings become essential in order to ensure proper information-sharing; the provision of the most appropriate support; the coordination of the support provided by the various agencies and professionals involved and cost effectiveness. In some cases this can also help to prevent a phenomenon known as 'splitting', where parents side with one professional against another, rather than face their own issues. It such cases 'conflict by proxy' can develop. (Tilman Furniss)

Here's another example of the effectiveness of working together. A fourteen year old had been missing a lot of school with health related issues. Her mother was worried that her daughter was developing bipolar disorder, just as she herself had done at the same age. (This is a distinct possibility, as it appears to be very inheritable: one in four chance with one parent, one in two chance with two parents.) The mother was very worried and she kept interfering with the school's plan to keep the girl in school. Things only started to improve when we found a CPN to work with the mother while the girl

had a CAMHS worker that Mum respected and they all met with the school nurse and teachers to contain the Mum's worries.

3. Making meetings more effective

There are two ways of managing such meetings which seem to help engagement in the process and make the meetings more effective. The first is to go round everyone once or twice asking what they would like to get out of the meeting. This agenda is carefully noted, perhaps on a flip chart. This produces commitment to the process and is the beginning of goal-setting for the pupil-family-school system. This is noted down so that it can be checked at the end of the meeting. It also enables people to trust each other and to be accountable for the tasks they have accepted to move things forward. Many people are concerned to avoid conflict around decision-making. Ground rules about how to manage differing opinions can be suggested and agreed by those present at the meeting. It is important to be able to listen to, and contain, different opinions as they can be very valuable in producing creative solutions. Leoncini has described trust, creative conflict, commitment, accountability and goals as being the five important attributes of good teams. These have to be the attributes of all the spontaneously forming teams around children that the CAF process encourages.

Where situations are very tense and difficult, I use the method of talking circles or hocokah used by Native Americans with great success (Mehl-Madrona). In this model each person speaks in turn, without interruption, holding a talking stick (usually a felt tip pen in schools). They speak for themselves and don't comment or critique anyone else's talking. The circle is gone around as many times as needed until everyone feels heard and is able to say 'I'm done'. The peaceful resolution obtained is quite remarkable. It is as though everyone is thinking within a bigger mind. It allows a deep listening, and a deepening expression, which are seldom experienced in our culture where everyone expects to react to everything that is said and so becomes defensive. It is known that a mind prepared for 'reaction' is not capable of 'reflection'. Tom Andersen described this as achieving the observer position. Michael West has researched NHS team functioning where there are good outcomes and the major key feature is the capacity to reflect. There is no reason to suppose that this couldn't also happen in schools!

4. Family Trees - Genograms

Drawing a genogram or family tree is a staple of any family therapist and of many GPs who have been trained in Family Systems Medicine (McDaniel et al, Asen et al, 2004). In the 1990s I worked for a couple of years as a family therapist in a residential school for children with emotional and behavioural difficulties. For each child I saw, we completed a family tree. One day I went into work to find a thirteen year old lad sitting outside my room waiting. 'Miss,' he said. 'I'm so pleased we filled in my family tree last week. There's something we left out last time. The baby born before me died and I know my Mum never got over it. I know she and my Dad split up because of it and then I tried to cheer her up. So I took to stealing to get her what she wanted because we were so poor.' He had reflected and made sense of his life in a more adult way than anyone else in his family (and his previous professional network judging by the notes!). Work was then able to get under way to get him back home.

A seventeen year old Cassie came into the surgery wanting antidepressants. She had been sent by her Mum who had got depressed at seventeen and had taken several years to get the antidepressants that helped. Drawing a genogram helped show that the reason her Mum had got depressed was because both her parents had died in her late teens and there was little family support to help her to move on. Cassie's parents had separated when she was twelve and she had a younger sister. She thought she had had to be brave and not create any trouble for her Mum as she seemed so vulnerable. She didn't think her Mum had had any therapy, just pills. She came back in, a week later, to talk about her schoolwork. She was very anxious that day partly because her mother had been so angry that I hadn't prescribed any pills. She described how she hadn't wanted to do A-levels but felt school and her Mum had made her. She had wanted to go up to a neighbouring town to do a childcare course. She said that her school was putting her under pressure to get lots of assignments done that she didn't want to do anyway. She was terrified of making a fuss. We looked at the family tree to find family members who were good at saying what they wanted and she identified an uncle and grandfather on her Dad's side who were assertive. She went off to do research as to how they went about this vital life skill. We practised how she could speak clearly with her mother and with school to enable the changes she wanted to happen and the school nurse became involved to help as advocate with her head of year. Sometimes it is the quiet children and young people who are more worrying as they suffer in silence for far too long, unnoticed.

Doing a genogram needs to cover three generations. An anxious girl with some suicidal ideation aged twelve was brought in by her mother. The genogram revealed an extensive history of schizophrenia and bipolar disorder and several admissions with mental health problems in the family going back a couple of generation. This enabled a more rapid referral to CAMHS as some of the 'anxious thinking' seemed unusually severe and could represent a mental illness in a prodromal phase. Doing a genogram can enable a child to talk about drug and alcohol issues within the family. It can identify young carers who otherwise don't complain but are hampered in the development of their life skills. It can help identify the 'invisible male' – men who drift into vulnerable families and can create havoc with emotional physical and sexual abuse. It helps to make any child protection issues much more clear. Used within a professional team meeting it allows a deeper level of reflection about what should happen next.

5. Solutions-Focused Therapy for stressed teachers and teenagers

One of the observations GPs have of teachers is that they seem to feel entitled to be stressed. Somehow it is always the job that is at fault and not their reaction to it. In this they come into surgery as a victim of the system, particularly at OFSTED time. The first task is to get them out of the victim role. The second task is to help them make small changes and begin to notice their successes. The final task is to embed these changes so that they have more resilience to deal with future stresses.

Let's think about Mary. She is a fifty two year old English teacher whose slightly older teacher husband has been retired on ill health grounds for two years. Her parents are getting old and slightly infirm but don't require too much care. She has two young adult children who are producing grandchildren at a great rate. She has some menopausal symptoms of hot flushes. She has stopped swimming and walking because she is just too tired after work and there is so much marking to do. Recent staff changes at work

mean that as the most experienced teacher she has been given several classes that are challenging. She is getting symptoms of palpitations, near panic attacks, sleeping poorly and worrying excessively about her standard of work which she thinks is falling. She wants to be signed-off as sick and is already thinking of retiring on ill-health grounds. She hasn't spoken to her head of department, who is a bit younger than her, about how she feels.

The thoughts that go through my head at this point are:

- This is a tricky life-cycle point. She belongs to the 'sandwich generation' with younger and older dependents. Her husband has also become dependent.
- Teachers who retire on stress ill-health grounds often fail to become healthy and fail to feel well in retirement.
- The menopause causes anxiety symptoms, a temporary loss of cognitive functioning, a change in libido, and comes at a point when your children are producing grandchildren. The loss of a fertile role in life becomes even more evident.
- She would benefit from understanding how stress gets into the body and learning how to breathe to control some of the symptoms
- Her employer may have a solution that she hasn't thought about. She seems a talented person that they could do well to keep.

A solution-focused approach does several things. It stops ruminative problem talk. It empowers people to make small changes. It helps people to start noticing when the problem isn't a problem (exceptions). It gives people a vision of how they might be when they feel better, so they have something to aim for. It has been readily applied in schools with staff and pupils. Young people like it as a consultation style as they don't have to talk about feelings to get well. 70% of people respond well to it.

The model is simple and so easy to remember. It relies on identifying what the person has been doing already to get well, using scaling questions to identify what will be different (several things) when they have moved one step up the scale. It focuses on wellness because if people think about stress then stress hormones like adrenaline and steroids are released. However if people think 'wellness' thoughts, and undertake exercise, then dopamine, serotonin, oxytocin and endorphin (the so-called 'happy hormones') are released.

Mary was taught 7/11 breathing to control her panic attacks. This calmed her within the surgery. She was signed off for four weeks with an appointment in a week's time, on the understanding that this was a time to take stock. She agreed to exercise. She was at 2 on the scale of 0-10. A week later she was at 5 on the scale and was very surprised at herself. She had been talking with her husband about my observations. She didn't want to give up work as she loved it so much (serotonin) and wanted to find a way through (dopamine). She had shared some of her worries with him and a couple of girl-friends (releasing oxytocin). She had been walking and swimming (endorphins). Her next step up would be to talk to occupational health and her superior about a phased return and a thorough look at her responsibilities. She wanted to continue to exercise and feel more benefit of this before going back to work. She thought that she needed to change her diet and cut down her alcohol consumption. She wanted to try yoga. She was back at work in four weeks. Reflecting on the experience two months

later, she said how surprised she had been to learn that it was not all the job that was to blame, that she had to learn to control some of her symptoms.

Seventeen year old Cassie (mentioned above) loved the solution-focused technique. It seemed to suit her gentle, quiet and thoughtful approach to life. Some practitioners have described it as a 'mindful therapy' in the attention it pays to each person's unique journey. (The founder therapist Steve de Shazer was a Buddhist.) Cassie quickly picked up the scaling questions and liked the breaking-up of seemingly huge problems into small chunks that were completely manageable. She liked the pride she felt as she moved up the scale and the confidence she got through her explorations into her family. She said it was a skill she could always use. Each solution-focused consultation ends with a compliment alongside a homework task that has been developed during the consultation. It had been a long time since anyone had said anything complimentary to Cassie. A year later she was happily doing the childcare course that she had wanted to do and had left school in a helpfully negotiated way.

Hopefully this guidance will encourage staff to learn something new.

- Learning the skills of the meeting management can be done on an annual course run by Dr Mehl-Madrona in Cumbria.
- Genograms can be learnt on a foundation Family Therapy training course or by supervision by a Family Therapist.
- The BRIEF Therapy practice in London run regular courses on solution-focused working in schools.

References

Patrick Lencioni, 2002, The Five Dysfunctions of a Team A Leadership Fable,

Jossey-Bass – look on Google

Michael West, 2008, Effective Teams in Organizations, 2008, Chapter in: An Introduction to Work and Organizational Psychology. Chmiel, N.. (ed.). Oxford : Blackwell Publishing

Asen, Tomson, Tomson and Young, 2004, 10 minutes for the family, Routledge

Mehl-Madrona, Narrative Medicine, http://www.mehl-madrona.com/narrativemedicineonline.html

Tilman Furniss, 1991 , Multi-Professional Handbook of Child Sexual Abuse, Routledge
Andersen, T. (1987). The reflecting team: Dialogue and meta-dialogue in clinical work. Family Process, 26, 415-428 and Andersen, T. (Ed.). (1991). The reflecting team: Dialogues and dialogues about the dialogues. New York: W.W. Norton.

A.J.Macdonald Solution Focussed Therapy: Theory Research and Practice 2011

Ajmal and Rees, 2001, Solutions in schools, BT Press

For 7/11 breathing read 'How to liberate yourself from pain' by Grahame Brown