
PART I

THE TOOLS OF THE THERAPIST

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1

Therapy Fundamentals

OBJECTIVES

This chapter explains:

- *The attitude or mind-set toward clients that is at the foundation of therapy.*
- *Therapeutic language, including some specific words and phrases that come in handy in counseling.*
- *What to do in the first meeting with children and parents.*
- *Strategies for achieving buy-in from youth who do not want therapy.*
- *What can and cannot be kept confidential from the youth's parents.*
- *Two client-centered therapy techniques: reflection of feeling and reflection of meaning.*
- *Techniques for helping clients open up, including therapeutic books and games.*
- *How to use play and art in child therapy.*
- *Collaboration with professionals in other child-serving systems.*
- *When and how to terminate therapy.*

Case Study

Simplicity

Brent, a 5-year-old African American boy, was having trouble in kindergarten. The teacher reported that his academic skills and peer relationships were age-appropriate, but there had been repeated incidents of disobedience toward the teacher, accompanied by tantrums. Brent was not physically aggressive, but he screamed and cried, and it sometimes took 10 to 15 minutes to bring him under control. His behavior was generally pleasant and appropriate in between these outbursts, which had occurred two or three times per week during the several months since school began.

Brent lived with his mother, who was a single parent and registered nurse, an older sister, and his maternal grandparents, who provided much day-to-day child-care. The caregivers reported that Brent saw his father once a month or so and seemed sad at the end of the visits. The caregivers said there were no problems with Brent's behavior at home, and they described him as a happy, energetic, cooperative child.

The therapist's impression of Brent was consistent with his caregivers' description. In both play and conversation, his behavior was organized and compliant. His play with puppets depicted exciting activities and interactions, with no unusual themes of distress or defiance. He loved playing catch with a foam ball the therapist had in his office. Because Brent had exhibited no problems prior to starting school, the counselor made a diagnosis of Adjustment Disorder with Mixed Disturbance of Emotions and Conduct.

While most of the chapters in this book are organized around specific theories of psychotherapy and categories of mental health disturbance, in this chapter we begin with basic therapeutic principles and procedures that cross-cut theoretical orientations and apply to most diagnoses. Research has produced a great deal of evidence that such shared or common factors of therapy are central to its effectiveness (Ahn & Wampold, 2001; Baskin, Tierney, Minami, & Wampold, 2003; Grissom, 1996).

This chapter may make therapy sound simple—and, in a way, it is. In another way, therapy is quite complicated, as the next 14 chapters will make clear. We will begin at the beginning and build an understanding of therapy from the ground up.

The Therapeutic Orientation toward Clients

While the activity of psychotherapy is based largely on theory and technique, there is a certain attitude that lies at the foundation of our endeavor. This attitude orients us to our job, organizes our efforts, and governs the interpersonal tone of our behavior with children and families. The idea behind the therapeutic orientation is so simple that it might sound like a cliché, but its ramifications are important to consider. The moment-to-moment behavior of therapists should convey that they are there to help the client with her problems and her life. This is the role of therapists as established by licensure and relevant laws.

Although this point seems obvious, it is worth making because parents and children sometimes fear their therapists are *not* there to help. Youth sometimes think that being brought to counseling represents a serious form of getting in trouble, and they may think the therapist's job is to punish them or to forcibly bring their behavior under control. Children and parents sometimes think that therapists are there to evaluate and judge them—to identify and point out their failures and inadequacies. This fear seems particularly common in low-income and ethnic minority families who feel intimidated by encounters with "the system" (S. Sue, 1998; Sue & Sue, 2002). Therapists should be alert to the possibility of these concerns in clients so they can counteract them either with explicit explanations of their role or by making sure to convey a help-focused agenda in their way of interacting with families. If families seem more concerned about your approval or disapproval than about benefiting from counseling, it may be useful to say something like: "Remember—You don't work for me; I work for you."

When counselors translate this attitude into behavior, they create an interpersonal environment that is therapeutic for clients. During the time they are together, the cli-

nician is devoted solely to the child's welfare, with no needs of his own involved in the relationship other than professional needs for remuneration and meaningful work.

The therapist models an attitude toward life that is adaptive and constructive. She does not hesitate to discuss any issue or experience, no matter how awkward or upsetting. The counselor's stance toward the client does not change whether the child reveals things about himself he considers wonderful or things he considers shameful; the therapist's unvarying desire is to understand and help.

The issue of counselors making judgments about clients has two aspects. The therapeutic attitude is based on unconditional acceptance, respect, and caring about the client *as a person*. However, this attitude does not include unconditional approval of all client *behaviors*. On the contrary—in many cases, our effort to assist clients necessarily involves helping them to change undesirable behaviors. This two-part attitude can be explained to children using words like the following:

“I like *you*; I just don't like what you did. In fact, I like you too much to want you to go on doing what you did.”

The idea of unconditional respect for clients generally makes sense to therapists when they read about it in a book but, in the midst of real clinical work with difficult clients, maintaining this attitude is not always easy. Our commitment to a humanistic, forgiving view of people is sometimes tested by contact with child and parent behaviors that are obnoxious, mean-spirited, and cruel. No one knows how to increase the resilience of the therapeutic attitude, but we try to provide some guidance by offering personal, experience-based reflections.

The therapeutic attitude seems based on an awareness of fundamental characteristics of human life. People, especially children, do not choose the situations in which they find themselves. They do not choose the family environments, neighborhoods, or schools that influence their development. People also do not choose the genetic endowments, physical constitutions, and neurophysiologically based temperaments that, operating from within, strongly influence their experience and behavior. Within these constraints, people try to do the best they can for themselves in the world, seeking happiness where opportunities present themselves and avoiding pain when dangers seem apparent. People become therapy clients when their efforts to adapt are disrupted by neurophysiological dysregulation, environments that are harmful or poorly matched to their needs, unrealistic thinking, and painful emotional states. As a result, clients often flail, grope, and fail in their efforts to be happy, sometimes leaving painful experiences for other people in their wake. But clients do not wake up in the morning and decide to spend the day making themselves and others miserable—these are unchosen outcomes.

Therapists' initial, natural response to obnoxious or purposely hurtful behavior is often emotional distancing, perhaps even revulsion. However, we find that the most effective response to this therapeutic challenge is, not distancing, but attending more closely to the parent or child, because increased awareness of the other person's experience usually counteracts anger and disrespect. Looking closely into a person's face, feeling the rhythm of her speech and movements, and perceiving the emotions, thoughts, and pain behind her behavior usually strengthen our appreciation of that person's humanity. When there is a threat to your therapeutic orientation, we suggest trying to imagine what life feels like, moment to moment, for the parent or child as she wakes up in the morning, goes about her day, and goes to sleep at night. If you try this, we predict

that your respect and concern will be rescued, not by abstract humanistic principles, but by the little things people say and do that express something intimately human.

The Therapist's Interpersonal Style

The theoretical orientations described in the chapters to follow differ somewhat in their recommendations for the counselor's style of interacting with clients. Nonetheless, we will offer some initial suggestions that may apply across the various approaches. There has been a good deal of research on client responses to different styles of therapist behavior, although these studies have generally focused on adult clients. We make use of this indirectly applicable research and our own clinical experience with youth in formulating our suggestions.

One of the most robust findings in psychotherapy research is that the quality of the therapist-client alliance predicts continuation in therapy (versus dropout) and improvement in client functioning (Horvath & Bedi, 2002; Karver, Handelsman, Fields, & Bickman, 2005; Martin, Garske, & Davis, 2000; and see Shirk & Karver, 2003, for a meta-analysis of studies of child and adolescent therapy). This association has been found across different theoretical orientations and diagnostic groups.

The next question is: What can therapists do to engender positive relationships with clients? Our response to this question draws on the efforts of a task force of the American Psychological Association that reviewed research on the therapist-client relationship (Steering Committee, 2002). Therapist *empathy* seems to be the single most important factor in the development of the treatment alliance (Bohart, Elliott, Greenberg, & Watson, 2002). In addition, research indicates that most clients respond best to counselors who are friendly, kind, and warm (Najavits & Strupp, 1994). A review of studies by Orlinsky, Grave, and Parks (1994) also identified client perceptions of therapist credibility

and professional skill as important to the therapeutic relationship. Thus, research indicates that therapists should try to combine the behavioral qualities of professional expertise and empathic warmth—science and heart—in their interpersonal style with clients.

Perhaps because of the early influence of psychoanalysis, the traditional way for therapists to behave with clients has been a neutral, observant style in which the therapist does not initiate topics of conversation but waits to hear what the client brings up. However, most nonanalytic approaches have not recommended this style, and research on therapeutic relationships indicates that most clients do not connect well with reserved, distant counselors. Instead, treatment alliances are strongest when the client perceives the therapist as a real person who is authentic in the relationship (Klein, Golden, Michels, & Chisholm-Stockard, 2002), and when the client believes the therapist likes and cares about him (Farber & Lane, 2002). In our clinical experience, we have heard young clients complain about past therapists who “sat there and waited for me to say something,” and who “stared at me and didn't talk.” Therefore, we suggest that counselors allow themselves to be natural and emotionally present in the context of a professional but genuine person-to-person relationship.

The therapist-client alliance seems to develop best when counselor behavior toward the client is friendly and caring, but without an emotional intensity that would change the relationship from a professional to a personal one. Therapists should be cheerleaders

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for their clients, rooting for them to make progress against their problems. Our faces should light up when we hear reports of success and should express concern when setbacks occur. However, there should be boundaries on the expression of these natural reactions, which should not be so intense that clients come to worry about letting us down.

Clients sometimes ask therapists questions about themselves, with the most common one probably being, “Do you have kids?” The traditional, psychodynamic view has been that such questions reflect emotional issues and that answering these questions interferes with exploring the concerns beneath them. Accordingly, the recommendation has been to respond to personal questions with other questions, such as, “What do you think?” However, many client inquiries seem to reflect nothing other than ordinary curiosity, and a sphinx-like refusal to give straight answers may frustrate clients. We suggest that counselors respond to appropriate questions by providing ordinary information. Therapists who think the client’s question might express an underlying concern can investigate this possibility after the question has been answered.

Counselors should probably not employ the same behavioral style with every client but should tailor the details of their interpersonal behavior to accommodate each youth. Therapists cannot be chameleons but, when they are sensitive to client preferences and moods, counselors can adjust their behavior to provide what clients need at the moment. For example, it makes sense to be warm and soft when clients are distressed and hurting. In contrast, tough adolescents generally do best when their counselors have a strong, direct style. Youth who do well in school may admire your professional stature and want to hear about your academic background. Youngsters who rebel against authority need firm limits, but they also feel most comfortable with therapists who, rather than being formal and proper, present themselves as casual, approachable people who like to have fun, too.

Therapy Language

Therapists’ talk should consist of ordinary language and tones of voice. We would caution against adopting a stereotypically therapeutic speaking style because this may come across as affected to clients. Counselors should avoid technical jargon, intellectualized language, and a “touchy-feely” style. Youth generally like therapists who talk like regular people, not “shrinks.”

The phrases “It sounds like . . .” and “It seems like . . .” are convenient and useful as long as they are not overused. Statements beginning with the pronoun “I”—such as “I think that . . .” and “I wonder if . . .”—have a straightforward quality. For example:

- “I think you would like to do well in school, but you don’t know how to go about doing that.”
- “I can see that you’re mad at yourself for losing your temper with him.”

Much therapy talk involves words for feelings. Most preschool children know basic emotion words like “sad,” “mad,” “scared,” “fun,” and “happy.” Most elementary school children know words like “nervous,” “disappointed,” “excited,” “upset,” and “bored.” Adolescents can usually talk about still subtler varieties of emotion.

Discussion of emotional issues need not consist entirely of words for feelings. Talking about motives, goals, meanings, and reactions also builds self-awareness and clarifies

issues. Clinicians talk about what clients want and do not want, what they hope for and fear, and what they like, love, dislike, and hate. As other examples:

- “You love the teddy bear your aunt brought you, and it was horrible when Debbie spilled grape juice on it.”
- “You really had your hopes up, and it was disappointing when she said no.”

Ambivalence can be described as “mixed feelings” or “having two different feelings about the same thing at the same time.” Motivational conflict can be discussed by referring to “parts of you” that want different things. Even more simply, counselors can portray the co-occurrence of conflicting emotions by using the word “and” to connect them in the same sentence and by using a tone of voice implying that such co-occurrence is possible and natural. For instance:

- “You’re scared to go, and you’re excited to go.”
- “You want to tell me what happened, and you don’t want to tell me what happened.”

Several words and expressions come in handy for conveying certain concepts to clients. The word “work” is a good description of therapy-related efforts (e.g., “I’m glad you’re ready to start working on your behavior”). The best single term to describe your job with the client is “help.” Because children think in terms of “good” and “bad,” it is usually unnecessary to replace these words with fancier terminology such as “positive” and “negative.” The word “choice” is useful when discussing client actions because it highlights their capacity for control and responsibility. Thus, it is often useful to talk about “good choices” and “bad choices.” The word “mistake” is a useful term for negative behavior. Therapists sometimes distinguish between the persona the client presents to the world and “what goes on inside.”

When working with children, counselors face the challenge of discussing complex issues in language that young people can understand. Finding words to use with child clients requires us to leave behind the familiar complexities of technical terms and abstract thought and to distill our messages into stark, basic terms. Albert Einstein said that if you really understand something, you can explain it to a 5-year-old. We have no idea how this pertains to the theory of relativity, but it does seem to apply to the life issues of concern in therapy. For example:

- “You want to be good, but sometimes it’s fun to be bad.”
- “You feel like it’s wrong to be mad at someone you love.”
- “You think the bad things that happened to you must mean you’re a bad person.”

Getting Started

Meeting the Parents

Most child therapists begin treatment by meeting with the parent(s), for one session, to obtain a description of the youngster’s problems and the parent’s goals for therapy. This

practice is consistent with the legal structure of child therapy, which occurs at the behest of parents or guardians. The goal of this meeting is to establish a treatment contract—not as a written, legalistic document but as a shared understanding of the purpose and nature of what will occur.

First sessions consist mostly of clinician questions and parent answers about the child's presenting problems, development, general functioning, and history. It is usually best to start off with a simple, open-ended question such as, "What brings you to our clinic?" "How can I help you and your child?" or, for an informal tone, "So, what's going on with Brent?" Specific questions depart from the parent's answer to this first question.

After the therapist has inquired about the child and family, he should invite the parents to ask any questions they have about him, particularly his credentials, education, experience, and methods of working with children. This part of the meeting is like a job interview for the therapist in the sense that the parents, as consumers, are entitled to inquire about the services they are thinking about purchasing. In our experience, however, while parents appreciate the invitation to inquire, they rarely have any questions about professional qualifications. Most of what they want to know they have already learned in the process of talking to the counselor about their child's difficulties, namely, whether the clinician seems like a nice person who knows what he is doing. Therapists engender this form of trust when parents feel that, during the sessions, their child's welfare is the therapist's only concern in the world.

First meetings should produce a decision about whether the therapist is the right person for the job of treating the child. The clinician is responsible for being ethical about her part of the decision, which depends on the fit between her areas of expertise and the child's problems. If the clinician is unsure how to treat some of these difficulties, she should make an appropriate referral.

Parents generally want to know whether therapy is likely to help their child. We suggest addressing this question with a combination of scientific information and human response. As discussed in Chapter 8 on treatment planning, outcome research indicates that, for most forms of disturbance, therapy produces improvement for approximately 70% to 75% of clients. Texts by Mash and Wolfe (2005), and Orvaschel, Faust, and Hersen (2001) provide more specific prognostic information based on diagnosis. However, this type of information is the beginning, not the end, of what parents want to know. Guarantees should not be given, but most parents appreciate sincere statements of determination and realistic optimism about the new endeavor they are embarking upon. Probabilistic statements based on research with large samples of clients are usually less meaningful to parents than statements like the following:

- "I believe I can help your son."
- "Therapy can certainly help children with problems like Brent's."
- "I'm going to do my best to help Alison. I can see what caring parents you are, and your description shows that Alison brings important strengths to therapy. We've got a lot going for us here and, if we work as a team, I think things are going to get a lot better for your daughter."

Parents sometimes ask how long therapy will take. Although this is a reasonable question, the state of our science is such that we cannot give precise answers with confidence. Successful therapy typically involves about 5 to 12 sessions, but there are

exceptions on both ends of this range. Clients who function effectively in most life areas and who have mild, circumscribed problems tend to need less therapy than clients with serious, pervasive dysfunction. Brent was an example of the first type of client, so the clinician predicted that his therapy would be brief.

First meetings usually conclude with talk about scheduling. Child therapy typically occurs on a weekly or bi-weekly basis. Weekly sessions seem to work best at the beginning, especially with young children who might have difficulty maintaining a sense of continuity between more widely spaced meetings. After counseling is underway, bi-weekly sessions may be more convenient and efficient. The family's practical needs and preferences are an important consideration in scheduling.

Meeting the Child

The next time you go to the waiting room to meet the parent, the child will be there too, waiting to meet his new therapist. Counselors should greet clients with an attitude combining warmth, concern, cheerfulness, and curiosity. We want clients to feel we are happy to see them and that, as part of our effort to help, we are interested in learning about their experiences and behaviors.

One way to begin the process of building rapport is to offer clients small choices such as asking them where they would like to sit, what toys they want to play with, how to word a description of their problem, and so forth. Opportunities to make choices like these provide clients with a sense of control that prevents them from feeling swept away by a mysterious process.

With young children (under 6 years old or so), explanations of therapy should wait until the child has explored the room, investigated the toys, and found out what it is like to be with the counselor, because these aspects of experience are usually more important to them than verbal explanations. With older clients, it is respectful to get right to the point, so the youth understands the situation she finds herself in.

Providing children with an explanation of therapy might seem like a difficult task. Usually, however, it is not. For some reason, most children seem to have an intuitive grasp of therapy, so that a few sentences of explanation are all they need. When Freud first proposed that talking about emotional problems could lead to their resolution, the scientific establishment of the time rejected his proposal as ridiculous, but this idea seems to make sense to children.

There are two things the child needs to understand, namely, what therapy is and why his parents think he needs it.

One way to begin is to ask the child what she understands about the purpose of the visit, based on what her parents have told her. Frequently, it is surprising how little clients know, perhaps because their parents think an explanation would cause resistance. Therapists can convey a message of respect and collaboration by offering a clear explanation of what's what. There are two things the child needs to understand, namely, what therapy is and why his parents think he needs it. You can start off by asking:

"I'm a therapist. Do you know what a therapist is?"

Clinicians with doctoral degrees have access to a word that is handy for explaining therapy to children, because youngsters understand that doctors help people with physical problems. The terms "talking doctor" and "feelings doctor," along with a statement

that, “I’m the kind of doctor who doesn’t give shots,” help to convey the idea of counseling. Regardless of the clinician’s academic degree, words like the following can be used to explain therapy to young children:

“Therapists help kids with problems. These problems have to do with feelings, behavior, and getting along with people. Like, if a kid was real sad, or mad, or she got in a lot of trouble at school, a therapist could help with that. In therapy, we talk about what’s wrong, and we find ways to make things better.”

Then the counselor should address the specifics of the youth’s situation. Here is an example for an older child:

“Your mom and dad thought it would be a good idea for us to talk. They are worried because you seem sad a lot of the time. They said you don’t go out and do things the way you used to and, a lot of the time, you mope around like nothing is any fun. They also said that when things go wrong, like difficult homework, you get upset and put yourself down by calling yourself stupid and saying you can’t do it. Your parents don’t think this is okay because they want you be happy, so they brought you here to see me because I’m a therapist and this is the kind of thing I help kids with.”

Research on the placebo effect indicates that, whether the target of intervention is physical or psychological, expectations of improvement tend to be self-fulfilling, so that optimism promotes healing (Duncan & Miller, 2000; Snyder, Michael, & Cheavens, 1999). Clients who expect therapy to work achieve better outcomes (Joyce & Piper, 1998). Therefore, it is therapeutically useful for clients to depart from their first session with feelings of hope. Counselor statements about the likelihood of change will not be credible if they are unrealistic, but counselors can acknowledge difficulties while expressing determination and offering hope in a trusting relationship:

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“Next week, when you come back, we’ll roll up our sleeves and get started. We’ll put our heads together and think of different strategies. If one thing doesn’t work, we’ll try something else, and we won’t stop until things get better.”

One good line with which to conclude is, “I’m glad you came to see me.” If said with the right tone of voice, this statement refers both to the seriousness of the problems and to the therapist’s optimism about helping, while also communicating warmth and a sense of fun about the process.

Achieving Buy-In from Resistant Clients

Child psychopathology takes many different forms but, beneath this complexity, there is a distinction that defines two large, basic categories of disturbance (Achenbach, 1991a, 1991b, 1991c). **Internalizing** dysfunction consists of symptoms related to emotional distress, such as depression, anxiety, low self-esteem, somatization, and withdrawal. **Externalizing** dysfunction consists of overt, disruptive behavior problems such as noncompliance, aggression, and delinquency. In internalizing, the problem is with

how the youngster *feels*. In externalizing, the problem is with what the child *does*. Many youth have both forms of dysfunction, but there is a tendency for one or the other to predominate.

These two types of disturbance are often associated with different attitudes toward therapy. Because internalizing dysfunction involves distress, these children are often willing to participate in counseling, and they usually share their parents' goals for treatment. When internalizing youth resist therapy, it is usually because they are afraid the experience will be painful for some reason. For example, some children fear that the counselor will yell at them, ask them embarrassing questions, or demand they try to do things they are incapable of doing. Such fears, once verbalized, are usually easy to reassure. Also, therapists can reduce such clients' anxiety by giving them some control over the process. Here is an example of a response to a client who was afraid that he would not know how to answer the counselor's questions:

"I don't want you to have a bad time here, so we have to make sure that doesn't happen. Here's your job: If I ask questions that you don't know how to answer, you go like this (therapist's hands make a 'T' for timeout) and say 'hey, Ms. Dorman, I don't know how to answer these questions.' Then I'll pull back and try to think of better questions. Okay? Let's practice a couple times."

With externalizing youth, sources of resistance to therapy may be more substantial and difficult to resolve. Typically, these clients see nothing wrong with their behavior and blame their problems on other people. Given this view, there is no reason why the client would want to participate in therapy. For example, if her definition of the problem is, "My parents are always nagging me about school," and she believes homework is for nerds, then her goal would be for her parents to accept her under-achievement, not for her to improve her performance.

Therapists need to work hard to achieve buy-in from externalizing clients, and they need to realize that a little bit of buy-in is better than none at all. The task is to think of changes in the youth's life that would be desirable, or at least acceptable, both to him and to his parents. One strategy for accomplishing this is to portray the parents' expectations as unalterable facts and then to invite the youth to join you in a search for ways to improve his life *within* this constraint. Looking at the problem from the client's perspective sometimes makes it possible to reframe therapy in a way the youth finds appealing. For example:

- "We need to find a way to get your parents off your back. But I'm talking about something that will work, not just wishing they'll let you flunk out of school."
- "Your parents aren't going to budge from their rules. Given that fact, how can I be helpful to you? How could we make things more livable in your family?"
- "Your parents know they yell at you too much; they told me so. We're thinking of strategies for changing that—there will be a big part for you to do, too."

Externalizing youth are not usually happy, and therapists can sometimes funnel their unhappiness into the development of treatment motivation. Questions like the following imply that therapy could create changes desirable to the youth:

- “Are you happy with the way things are in your life (or family, school, etc.)?”
- “What would you like to change about your life (or family, school, self, etc.)?”

Therapists need to form alliances with both the parents and the youth. It is difficult but not impossible for the counselor to position himself midway between the two parties in such a way that both perceive him as an ally. One useful technique is to use the word “we” to convey that you share the client’s or parent’s goals. For example:

- “We’ve got to figure out some way for you to have fun after school but still get enough done on your chores so that Mom can relax a little, too, when she gets home from work.”
- “If we can figure out a way to get your grades up, I’ll be able to help on the clothes problem with your parents. If we work together on this, I think we’ll get somewhere.”

Another strategy for inducing resistant youth to come to therapy is to offer a trial period. The parents can say they expect the youth to give counseling a legitimate try for three or four sessions, or even for just one. Once therapy gets started, most youth are willing to continue. However, offering a choice is an appropriate strategy only if the parents would be able to accept either decision the youth might make.

Despite the therapist’s best efforts, young clients are sometimes involuntary participants in therapy. This is not the end of the world. Parents sometimes ask whether there is any point in forcing youth to receive counseling against their will. Generally, the answer is yes. Clients with disruptive behavior and conduct disorders *usually* begin therapy involuntarily, but the outcome research reviewed in the chapters on these disturbances indicates that positive outcomes are possible, nevertheless. Sometimes, it is necessary for children’s participation in therapy to occur as a result of parental authority.

Confidentiality

The ethical and clinical issues involved in confidentiality for child clients are potentially complex, and the relevant laws vary slightly from state to state. This chapter does not address these complexities but we offer guidelines that should suffice in the vast majority of cases. If necessary, therapists can do additional reading (e.g., Behnke & Warner, 2002; Rae & Fournier, 1999) and/or consult with colleagues. It is particularly useful to request guidance from one’s state professional board or association because, in the event of an allegation of misconduct, compliance with these authoritative opinions provides an effective defense.

In work with adults, therapists cannot divulge any information about the client without her consent unless doing so is necessary to prevent either self-harm or harm to another person (e.g., when there is suicidal or homicidal intent), or there is a court order requiring the therapist to divulge information about the client. The situation for children and adolescents is completely different. Clients under age 18 have no legal right to confidentiality or privacy from their guardians. In fact, parents have a legal right to all information about their child’s therapy—if they insist on it.

This description of the law might make it sound as though therapy must involve difficult conflicts between the child’s need to talk and the parent’s right to know.

Fortunately, in practice, things usually work out quite easily. Most parents understand that, if therapy is to be effective, clients need some privacy in which to speak openly. Clinicians should present both sides of this issue to parents so they understand both their legal right to information and the clinical value of privacy for the child.

There are two types of information that parents should receive even if the child wants the information kept confidential. First, clinicians must inform parents about any danger of harm to the client or another person. Therapists must tell parents about client statements related to abuse, neglect, use of illegal drugs, and significant violations of the law. Information about abuse and neglect must also be reported immediately to the state child protection agency. Client disclosures about sexual behavior and circumventions of family rules are in the gray area; decisions about reporting this type of information should depend on whether there is a danger of harm and on the overall therapeutic situation.

Clinicians should also keep parents apprised of the overall direction of their child's treatment, even if the youth wants this information withheld. This means describing what the child is working on, the treatment strategies being used, and the progress, or lack thereof, being made.

Therapist decisions about whether to report details of the client's thoughts, feelings, opinions, and experiences should usually depend on what the youngster wants. If the client wants this material held in confidence, the therapist should honor his request as long as this is acceptable to the parents. Often, however, youth *want* therapy material conveyed to their caregivers, either to help the parents understand them or for use in problem solving.

Children's desire for privacy from their parents generally increases with age, and adolescents usually need substantial privacy to feel comfortable in counseling. Nonetheless, there are unalterable limits to confidentiality in child therapy, and clients need to deal with this. Therapists can help by being honest about confidentiality issues. At the beginning of therapy, counselors should tell clients what can and cannot be kept private, so there will be no surprises. Thereafter, if the youth asks the therapist what he will report to the parent, an honest answer should be given. Counselors can also have clients participate in meetings with parents, so they know exactly what is said.

Maintaining Discipline

The issue of discipline during sessions rarely comes up in child therapy. Even youth who are defiant or aggressive in everyday life usually behave appropriately in the controlled environment of counseling sessions. Clients seem to view therapy offices as our turf, where they are visitors and we are in charge.

On the rare occasions when disruptive or aggressive behavior occurs, therapists must respond. The priorities, in descending order, are protection of people and property, the maintenance of order, and the provision of therapeutic experiences. In practice, there are no significant conflicts between these priorities. Next, we describe a progression of therapist responses to child misbehaviors.

The first response should usually be a brief, simple statement of the behavioral expectation for the child, such as "Please don't do that," "I want you to sit in your seat now," and "Stuart, put that down." If the child persists in a minor negative behavior, the best response is usually to ignore him and, when he stops, to reinforce the change of behavior. Chapter 10 on disruptive behavior disorders describes this technique in more detail.

If ignoring does not work, therapists should respond more assertively. These responses should not involve debate or negotiation, but they can include an explanation to help the child understand the reason for the limit placed on her behavior. These statements should portray the therapeutic setting as a safe place where rules have been established to ensure appropriate behavior. For instance:

- “Don’t throw that toy. There’s a rule here against breaking things.”
- “There’s no hitting here. I don’t hit you and you don’t hit me.”

If the child persists with misbehavior, the next step should be to state a negative consequence that will occur if he does not comply. These consequences could include time-out and the loss of toys or activities. The next response could be to get the parent from the waiting room and obtain her assistance. Finally, there is the option of ejecting the client from the session. This action might be combined with a request that the parent impose an additional consequence at home.

On rare occasions, clients, usually adolescents, express their anger toward the therapist by stalking out of the office. Sometimes it is useful to pursue the client and attempt to process this reaction. Usually the best thing to do is to follow him to the waiting room, give the parent a brief explanation, make an appointment for the next session, and let the client go.

Basic Child Therapy Skills

Assessment

The chapters that follow present detailed assessment recommendations based on theoretical orientation and diagnostic category. Here, we offer only some general, broadly applicable guidelines.

Research has produced a number of structured interview protocols that produce detailed diagnostic information. Although many of these protocols have good psychometric properties, the length of time required for their administration and scoring makes them impractical in most settings, and the old-fashioned clinical interview remains the predominant diagnostic procedure in clinical practice (Sattler, 2002). Freedheim and Shapiro (1999) present guidelines for general assessments of child functioning. Form 1.1 on the web site associated with this book presents their list of diagnostic interview questions for children, with questions about symptoms, relationships, and so forth. Form 1.2 on the web site presents an outline for diagnostic assessment that identifies areas for inquiry and suggests a structure for report writing. (The web address is <http://www.wiley.com/college/shapiro>.)

In everyday practice, the main assessment methods are interviews of the child and parent, and behavioral observation. Clinicians also use standardized measures when they want more structured, research-based information than interviews and observation can provide. The chapters following this one include brief descriptions of a number of such instruments. Because we included only widely used measures with well-established reliability and validity, our brief descriptions do not include reviews of the

empirical support for each instrument. Readers interested in psychometric information can consult the references accompanying the descriptions of the instruments.

To be useful clinically, assessments should aim not simply to assign a diagnosis but to illuminate the **etiology** of the client's problems. This word was originally defined as the cause of a disease (e.g., a pathogenic virus). In this book, we use the word "etiology" in a broad sense to include all factors that cause, maintain, or contribute to a mental health problem (e.g., poverty, trauma, family dysfunction, irrational beliefs). The word etiology originated in medicine, but our use of the term is not meant to invoke the medical model of mental health problems.

Etiological factors can be divided into two categories in relation to the child—internal and external. External factors include living conditions, parental behavior, reinforcement contingencies, and peer influences. Internal processes include beliefs, biases in thinking, coping and defense mechanisms, and emotions. Although both types of factor are involved in most problems, one or the other may be more important, and this information is useful for treatment planning because interventions should target the sources of client difficulties. If the assessment implicates external factors, the therapist should attempt to change relevant aspects of the child's environment, perhaps by training the parent in new child management techniques. If the assessment implicates internal processes, the counselor should focus on the client's thoughts, emotions, and so forth.

The questions listed in Table 1.1 apply to most clients and most problems. Versions of these questions can be asked of parents, teachers, and some older children and adolescents.

Questions for the child should focus on the thoughts and feelings associated with the difficulties. This aspect of the assessment aims to achieve an empathic understanding of what the disturbance feels like to the client. Questions such as, "Why do you think you ___" ("feel so nervous?" or "have trouble doing what Mom says?") may elicit information about the causes of the problems and their meaning to the child.

Questions for clients are usually most effective when framed from their perspective.

Questions for clients are usually most effective when framed from their perspective. Such questions describe what the behavior in question feels like to the child, as well as what it looks like to adults. For example, instead of asking, "Do you stay in your seat in school?" one could ask: "Do you ever get bored and antsy in school, so you feel like you have to get up and move?" Therapists can encourage open, informative responses by acknowledging the pressures underlying negative behaviors, because this enables clients to disclose their difficulties without portraying themselves as bad kids.

Table 1.1 Widely Applicable Assessment Questions

-
- What does the problem consist of, exactly? What are the specific behaviors and emotions comprising the problem?
 - How frequently does the problem occur? How many times per day or week?
 - When does the problem happen? In what situations does it *not* occur?
 - When did the problem start? What was going on in the child's life at that time?
 - What has the child said about the problem that might reveal his thoughts about it?
 - What attempts have been made to solve or manage the problem? What have been the results of these efforts?
-

One formula for framing empathic questions makes use of the words “easy” and “hard.” These questions imply an unchosen quality in the problems. For instance:

- “Is it easy for you to pay attention in school, or is that hard?”
- “Is it easy to feel cheerful most of the time, or does life sometimes seem crummy, so you can’t help feeling depressed?”

Questions that use the words “trouble” or “problems” to refer to negative behaviors also provide a palatable way to acknowledge difficulties. For example:

- “Do you sometimes have trouble following your parents’ rules?”
- “Do you have any problems with fighting?”

Assessment does not cease after the intake but is an ongoing element of therapy. Counselors monitor the child’s presentation on multiple channels by attending to their words, physical behavior, tones of voice, facial expressions, and body language. They appraise and conceptualize different forms of information, including the client’s in-session functioning, reports from parents and teachers, and the child’s history.

Clinicians who are trying to understand clients may find it useful to ask themselves the question, “Why *would* a youngster feel and behave this way?” For example:

- “Why would a child be so afraid of a father who seems so nice?”
- “Why would a 10-year-old spend so much time alone in her room?”
- “Why would an adolescent run away from home?”

Clinicians tend to focus on problems, because this is why clients come to us, but assessment should also include attention to positive aspects of the child’s life. Focusing exclusively on problems results in an incomplete, distorted picture of the youngster. Treatment should make use of the client’s strengths, and this cannot be done unless the therapist knows what these resources are. Important examples of client strengths include awareness of the problems, ability to form relationships, openness, determination in pursuit of goals, artistic talents, sense of humor, and so forth.

The most important part of Brent’s assessment was the clinician’s phone conversation with his teacher, who noticed a pattern: In practically all the incidents of concern, Brent had been enthusiastically focused on some toy or play activity when the teacher interrupted him with a directive to move on to something else. He was apparently unable to accept this external direction and shift his attention away from the activity in which he was immersed, and the teacher’s efforts to get him to do so resulted in tantrums.

Session Structure and Activities

Child therapists often spend the first 10 to 15 minutes of therapy appointments talking with the parent. Counselors ask about recent life events, changes in the child’s functioning, responses to therapy, and interventions conducted by the parent at home. Then, when the parent leaves and the child comes in, the clinician has an external view of the behaviors in question, and she needs to hear the child’s view. For example:

THERAPIST: How have things been going?

CLIENT: Pretty good.

THERAPIST: That's not what your Mom said.

Much child treatment involves going back and forth between the parent and client and trying to integrate their two perspectives in a way that does justice to both. For instance:

- “Your Mom said you were really mad the other night. What was going on?”
- “Your Dad told me about the soccer game. What happened?”

When clients, especially adolescents, are struggling with internal issues, and conflict with parents is not the problem, the youth should have plenty of space in which to develop his own, autonomous relationship with the therapist. This might mean that the teen attends most sessions by himself, and the parent and counselor confer only occasionally.

One of the differences between child and adult therapy is that conversations in adult counseling focus mostly on identified therapeutic issues, while the talk and play of child treatment sometimes seem distant from the goals of therapy. The younger the child, the more this is the case. Children below age 7 or so usually have difficulty limiting their conversation to problems, and therapists who try to keep them on task may be frustrated as the child wriggles away from their control. Adolescents, too, usually need to spend some time talking about nonproblematic areas of their lives. Our recommendation is to strike a balance by pushing for some focus on therapeutic issues but also allowing the client some freedom to pursue topics and activities of his own choosing. One way for therapists to strike this balance is to follow the child's lead while being alert for signs of the issues they want to work on, so the therapist is ready to take advantage of the opportunities that occur when these issues are expressed in the child's spontaneous play or conversation. Sometimes it is useful to save a little time at the end of sessions for an enjoyable activity of the child's choice, because this reinforces the constructive work she has done and leaves her with a good feeling about counseling.

Therapists who follow the child's lead will find themselves spending session time playing ball, watching dramas enacted by puppets, and talking about videogames, parties, the cliques at school, and so forth. One technique for building rapport is to ask clients to bring to therapy the things they find enjoyable or interesting in their everyday lives, such as Pokeyman cards, photographs of friends, favorite music, or their prom dress. Sharing a snack helps some children warm up interpersonally. Clinicians with a strong work ethic might feel uncomfortable having fun with clients, and there might be thoughts like: “Uh oh—am I working? Is this therapy?”

The answer to both questions is probably yes, because the therapist-client relationship is the launching pad of counseling—you won't get far without it. Therapists join with young people on their terms by following their lead, sampling their interests, and experiencing what they enjoy. By entering the child's world in this fashion, you will get to know her and she will get to know you. While your eventual goal might be to get the client to do things your way, the way to start is often by doing things her way, because this establishes the connection that makes influence possible. On a simpler level, instilling an element of fun in the child's therapy experience may be a necessary precondition

for the goal-oriented treatment procedures that occur in this context. (Medicaid regulations that require a rigid, moment-to-moment focus on documented treatment goals betray an unfortunate lack of understanding of the way child therapy works.)

Child therapy might seem less efficient than adult work because its conversations are usually less focused on the identified issues of treatment. However, child counseling is sometimes more efficient than adult therapy because, when the conversation does alight on important issues, problems are often figured out and solved more quickly. Compared to adults, children may take longer to get ready but, when the right time arrives, they usually need fewer words to resolve problems because their thought processes are simpler and their difficulties are less entrenched. Child work often involves long periods with little therapeutic activity other than relationship-building, followed by short bursts during which the client's core issues are expressed, understood, and reworked.

When therapy produces important insights, ideas, and plans, we want these advances to take root in clients' minds, so they do not slip away. Counselors can galvanize the learning and memory process by being emphatic and earnest in stating important points. Therapists should not be afraid of sounding simplistic or corny, because children need simple, strong messages to hold onto. Counselors can facilitate the client's comprehension and memory of therapeutic material by providing occasional reviews and by asking the client to summarize what he has learned in therapy. For example:

THERAPIST: What should you do if you get mad?

CLIENT: Take a deep breath and use my words instead of my fists.

Putting ideas and plans in writing is an effective way to summarize and preserve therapeutic advances. The activity of completing worksheets, lists, and diagrams provides structure for conversation, facilitates comprehension, and provides documents that support the child's memory. Pictures can serve the same function for children who do not read. Older clients can keep notebooks in which they record material learned in sessions, homework assignments, and their thoughts about therapy-related issues.

Putting ideas and plans in writing is an effective way to summarize and preserve therapeutic advances.

When counselors and clients put things in writing during sessions, sometimes a little ritual evolves in which, at the end of the meeting, the child takes his paper to the office copy machine and reproduces it, so there is one for him and one for the chart. In addition to being an efficient means of documenting interventions, this is a nice way to end sessions, because many children enjoy operating grownup machines and because, symbolically, the child creates a physical object that connects therapy to life at home. Thus, when things go well, the child leaves with a written plan for handling the problem that the parent described at the beginning of the session. It is our version of a prescription (Table 1.2).

Empathic Reflection

Studies of adults have found that clients who express their emotions openly in therapy usually achieve more progress than those who do not (Greenberg & Malcolm, 2002; Greenberg & Safran, 1987). Although we know of no studies with children demonstrating a similar effect, clinical experience suggests that talking about feelings has

Table 1.2 Eric's Therapy Prescription

Why is it bad to yell at Mom?

1. It hurts the relationship.
2. It makes Mom feel bad and sad.
3. It is disrespectful.

The solution is for me to be in control of my emotions.

How can I be in control of my emotions?

1. Think before I act.
2. Take deep, slow breaths.
3. Remember my values: Nothing is as important as my family.

(End with the therapist's and client's signatures, with dates.)

several types of value. First, clients sometimes report that venting their feelings, or “getting things off my chest,” helps them feel better. The process of translating emotions into words may increase clients' ability to think about their feelings and so may facilitate coping. Finally, the client's verbalization of feelings is a necessary part of a number of therapeutic techniques.

The fundamental skills for encouraging expression and elaboration of feelings were first described by Carl Rogers (1951, 1957) and applied to children by Virginia Axline (1947). These methods were originally identified with **client-centered therapy**, but the techniques have spread far beyond the theoretical orientation in which they originated and are now part of the general therapeutic repertoire. There is little outcome research supporting the effectiveness of client-centered therapy as a complete treatment package for children, but this approach has contributed techniques that are generally valuable components of therapy (Gaylin, 1999).

Empathy means that the counselor adopts the client's perspective, views situations through her eyes, and vicariously experiences the client's emotions.

According to client-centered theory, counselors can engender emotional self-expression, self-awareness, and growth by conveying **empathy** to clients (Prouty, 1994). Empathy means that the counselor adopts the client's perspective, views situations through her eyes and, in a controlled, partial way, vicariously experiences the client's emotions. Empathy demonstrates to clients that another person can register and comprehend their experiences. Interpersonally, empathy provides a sense of being heard, understood, and accepted—a good feeling.

Empathy is an act of guided imagination. The way to empathize with someone is to listen closely to his words, observe his facial expressions and body language, use your preexisting knowledge of the person to provide context and, based on this input, to imagine what the experiences being described must feel like to the person. Empathy involves an aspect of emotional experience (albeit at a distance) in addition to intellectual understanding.

Empathy is therapeutic only if it is communicated to clients. The technique for doing so (which is the only technique used in client-centered therapy) is **reflection**. In reflection, the therapist distills the essence of what the client has said and echoes it back to her. For example:

CLIENT: My Mom and Dad have been arguing a lot. They keep yelling at each other, and sometimes my Dad says, “I've had it.”

THERAPIST: Their yelling upsets you, especially that thing your Dad says.

Sometimes, reflections simply rephrase or summarize what the client has said. In more complex versions of the technique, the therapist clarifies and amplifies what the client only hinted at or implied in his verbalization. By drawing out feelings and thoughts that had been expressed vaguely or partially, the therapist articulates the client's experience more fully than the client did himself. For instance:

CLIENT: My Mom and Dad have been arguing a lot. They keep yelling at each other, and sometimes my Dad says, "I've *had* it."

THERAPIST: You're scared they might get divorced.

Some reflections provide clients with feedback about emotions they have not verbalized at all. For instance, if a child stalked into the therapist's office with a scowl on her face, sat down without saying a word, and began scribbling furiously with a crayon, the counselor's feedback might be, "You seem mad at me today." Counselors identify and verbalize clients' feelings to teach them how to do this for themselves.

Therapists sometimes reflect the meanings contained in client statements without using emotion words. Here is an example of a **reflection of meaning**, as opposed to a **reflection of feeling**:

CLIENT: Katie and Jessica were playing Barbies by the swings, and I went over and said, "Hey, can I play?" but they said they didn't have enough dolls for three people.

THERAPIST: But maybe it seemed like, if they wanted to be friends, there would have been enough Barbies.

Reflections of feeling can usually be reduced to the formula, "It sounds like you're (upset, sad, mad, etc.)." However, we would caution against over-using this phrase, because doing so makes therapists sound like stereotypical shrinks. In videotapes of Carl Rogers doing client-centered therapy, he almost never says, "It sounds like you're . . ."

Reflections can be put in the form of questions as well as statements, for example, by asking, "Are you angry about this?" It makes sense to phrase reflections as questions when you are unsure of their accuracy and you want the client to say whether you are on the right track. Similarly, you can check out the accuracy of your hypotheses by summarizing what the client has said and then asking, "Have I got that right?" This type of question sends the respectful message that clients are the experts on their own experiences.

Clinicians can fall back on the reliable technique of empathic reflection at difficult times in therapy when they are confused by what the client presents and are unsure what to do next. Empathic reflection is usually the best thing to do when clients are highly upset. Empathy is also an effective response to clients who do not want to be in therapy and are required to attend by their parents (e.g., "You hate being forced to come here"). When in doubt, empathize.

Helping Clients Open Up

For most clients, therapist empathy is all that is necessary to produce useful talk about feelings. For some youth, however, counselors need to use more structured techniques to get the ball rolling. These techniques generally embed the unfamiliar behavior of

emotional self-expression in more familiar, game-like types of activity. Table 1.3 presents several such techniques.

Some of the activities in Table 1.3 require therapists to disclose emotions. The psychoanalytic approach discourages counselor self-disclosure, but this proscription is inconsistent with the research evidence. In studies of adults, counselor self-disclosure is associated with positive client outcomes (Barrett & Berman, 2001; Hill & Knox, 2002). Modeling self-expression may help clients feel comfortable by showing that therapists have feelings too and demonstrating how people talk about their emotions. In our clinical experience, youth particularly value therapist self-disclosures of one particular type, namely, descriptions of problems similar to their own that the therapist faced when he was young, along with an account of how the counselor coped with those problems. Of course, therapists should limit the intensity of their self-disclosures so they do not divert the focus of sessions from the client to themselves (Hill & Knox, 2002).

Davis's (1996; Davis & Sparks, 1988) books of therapeutic stories provide an engaging avenue of approach to emotional issues by presenting symbolic depictions of common childhood problems and possible solutions in story form. Sommers-Flanagan and Sommers-Flanagan's (1997) book called *Tough Kids, Cool Counseling* describes innovative techniques for engaging adolescents, including resistant ones, in therapy.

Sometimes, clients do not understand why therapists want to talk about negative experiences and painful emotions, particularly when the immediate effect of doing so is to make them feel worse. Counselors should offer clients a reasonable answer to the reasonable question of why we want to talk about bad things. For example:

"I know it hurts to talk about this stuff, and I sure don't want to bring you down. But there are reasons why people talk about painful things in therapy. Sometimes it helps to get things off your chest and share them with another person. Sometimes we can figure things out, so you understand your feelings better than you did before. Sometimes we can think of strategies, things you can do to help yourself feel better. But we can't do any of these things without talking about what's bothering you."

Table 1.3 Games That Facilitate Discussion of Emotions

- Graphic charts of "feeling faces" show drawings of facial expressions that depict different emotions. Therapists can review these charts with children and ask them to describe times when they experienced the various emotions.
- In the game called "feelings charades," the child and therapist take turns acting out emotions without using words, and the other person's task is to guess the feeling the actor is portraying.
- *The Talking, Feeling, and Doing Game* (Gardner, 1998) and *The Ungame* (Talicor, 2002) are board games in which cards direct the players to disclose experiences and information about themselves.
- In "Feelings Tic-Tac-Toe," the counselor draws a grid and selects an emotion for each of the nine boxes (Lowenstein, 1999). The players must describe an experience involving these feelings in order to inscribe their X or O in a box, with the goal being to get three in a row, just like in regular tic-tac-toe.
- A "feelings wheel" is a pie chart that represents emotions. The client chooses colors for the different feelings she has experienced and indicates their magnitude by the proportion of the pie chart they fill in.

Therapists can sometimes ease clients toward discussion of sensitive issues by talking about these problems in regard to *other* people, rather than the client herself. Therapists can talk about other clients who shared the youth's experiences with, for example, bullying, physical disability, or abuse. With older and more intellectual clients, counselors can describe research about the youth's issues; clients are often quite interested in such research. Placing problems in a general context often makes them easier to discuss.

When the focus does turn to the client himself, movement can still be incremental. It is sometimes effective to begin by discussing concrete, surface manifestations of difficult issues and then to move gradually toward the more abstract, emotional aspects of the problem. For example, discussion of a client's adjustment to his new blended family might begin by focusing on practical concerns such as changed routines and sharing his room. This conversation might then lead to more difficult issues such as the client's feeling that his original family relationships have been disrupted.

Making Sense of Problems

One of the first services therapists can provide is helping parents and children make sense of their difficulties. Explanations of problems span a wide range of complexity and depth. At the beginning of therapy, clinicians can offer families a basic sense of understanding by positing a few factors that help to explain the problems. For example, a therapist might explain a child's aggression as the result of witnessing domestic violence, or she might explain a client's anxiety as the result of unrealistically fearful thoughts. Even simpler explanations that do not identify causes but merely name, describe, and organize the problematic experiences also provide parents and children with a beginning sense of coherence. Here is an example for parents:

"It seems like life is just too much for Aaron right now. The challenges of school and peers feel overwhelming because, even though you might know he can do it, he doesn't. He's scared, so he's retreated into a shell."

Here is an example for clients:

"You miss your Dad so much when he doesn't visit, it's like a sad feeling in your heart that takes over your whole body and makes life miserable. That feeling is called depression."

These statements are not real explanations, but they provide an advance from the sense of disorganized confusion with which families often begin therapy. Clients feel encouraged because the therapist seems to understand their problems, which implies she will be able to respond effectively. Clear descriptions of the client's situation articulate the obvious in a useful way, cutting through the murky flux of moment-to-moment experience to identify the basic outline of the problems. These descriptions help by making the client's difficulties seem finite, comprehensible, and potentially manageable. For instance:

"Sometimes things happen that you don't like. The question is, what should you do then? Having tantrums doesn't seem to help. Would you be interested in talking about some other possibilities?"

Sometimes a description of a dilemma, with balanced attention to both of its sides, clarifies the challenge facing the client:

“You want to go out and have fun with your friends, doing the things they do at the times they do them, but you also want to get along with your parents. I guess your dilemma is that, so far, you haven’t found a way to do both of those things at the same time.”

Goal-Setting and Self-Monitoring

In the 1930s, industrial/organizational psychologists discovered that workers sometimes improved their output simply because they knew they were in a study and their performance was being observed, without any other intervention. This phenomenon, called the “Hawthorne Effect” (Adair, 1984), has a version in counseling: The activity of monitoring a client’s progress toward a goal sometimes has a therapeutic effect all by itself (Pope & Jones, 1996). Therapists can utilize this effect by making goal-setting and self-monitoring a part of counseling. Clients can measure their progress toward goals (e.g., number of arguments per day, or a depression rating on a scale of 1 to 10), and

Clients often begin therapy with an array of vague desires and dissatisfactions, and therapists can help by organizing these feelings into clear goals.

then root for their numbers to go in the winning direction. This technique is especially effective with competitive children who are stimulated by challenges.

Clients often begin therapy with an array of vague desires and dissatisfactions, and therapists can help by organizing these feelings into clear goals. These conversations often focus the client’s energies, provide direction, and impart hope that positive changes will be achieved.

Goals should be distinguished from wishes. Goals are most useful when they are realistic and they concern outcomes over which the client has some control, at least potentially. For example:

- “You have to go to school; there’s no way out of that. But I think we could change the way you *feel* about school, so you don’t hate it so much. Do you want to make that a goal for therapy?”
- “You have more power here than you think. I know your Dad’s girlfriend rubs you the wrong way, but I still think things would improve if you figured out a better way to deal with her.”

Table 1.4 presents additional examples of goals for therapy.

Planning Simple Solutions to Problems

In this section, we discuss very brief, simple therapeutic interventions. These strategies do not comprise comprehensive treatments, but they are helpful to some clients and, for a few, they might provide all the help that is needed. Therapists should not look past simple procedures in their search for complex, brilliant interventions because rudimentary flaws in basic psychological processes sometimes cause serious trouble for children, in which case therapists with the acumen to discern the obvious might be able to help in a quick, efficient, powerful way.

Table 1.4 Example Therapy Goals

-
- Feel okay, not sad, most of the time.
 - Feel happy some of the time.
 - Do what my mother says to do.
 - Follow school rules so I do not have detentions.
 - Feel half-way comfortable talking to my parents.
 - Have a friend over, or go to their house, at least once a week.
 - Talk respectfully to my father even when I'm mad at him.
 - Stop getting into fights.
 - Forgive myself for things I've done wrong.
 - Reduce and manage my anxiety about talking in class so I can do it.
-

In therapy at its simplest, the counselor and child sit down with a piece of paper and make a plan to solve some specific problem. At the top of the paper, the therapist writes a title describing a goal. For example:

- How to Cope with Stress
- What to Do if My Brother Teases Me
- What to Do if I Have a Scary Thought

Then, the therapist and client discuss the problems that have occurred, and they brainstorm ideas for preventing or managing similar occurrences in the future. Generally, plans should be selected and written down only if there is a consensus behind them, and the counselor and client both think the strategy might work.

Therapists can ask themselves several questions to facilitate their thinking about these plans. The first question is: What is the psychological process or function that the client needs to perform in order to master the problem situation? In other words, what does the child need to do that she is not doing now? The next question is: How can that function be distilled into a formula that the child can remember and use when she needs to?

For example, one 7-year-old boy got into trouble because he responded to situations too quickly, without taking a moment to think about what to do. The therapist and child drew several red stop signs, which the boy placed in his school desk, book bag, and room at home. The client learned to catch himself at the beginning of his reactions, and then he took out a stop sign and asked himself the question written beneath it: "What should I do?" Simple strategies like this are effective when they bring the right plan to the right situation in a way the child can accept, remember, and perform. Table 1.5 presents another example of a simple therapeutic intervention.

The activity of list-making sometimes helps clients organize their resources. For example, therapy for low self-esteem might include making a list called, "Good Things about Me," or "Reasons Why I am Not a Failure." Counseling for antisocial behavior might include making a list of the disadvantages of stealing. Children who feel their lives will be turned upside down by an imminent change such as a geographical relocation might benefit from listing aspects of their lives that will remain the same after the change occurs.

Sometimes, there is a sequence in which the therapist discovers the reason for a problem in her individual work with the child and, then, she uses this discovery as the

Table 1.5 A Simple Therapeutic Plan

<i>How to Get Rid of Tantrums</i>
Mom or Dad can:
1. Give me some food.
2. Give me a hug.
I can:
1. Pet my dog.
2. Go away from the problem and think about something good.
No more tantrums. Do what needs to be done and <i>be happy!</i>
(End with signatures of client, mother (or father), and therapist.)

basis of an intervention for the parent to implement. For example, one child's anxiety symptoms turned out to be the result of rumination about his family's financial situation. The therapist figured out that he misinterpreted his mother's ordinary complaining about bills as an indication that the family was running out of money. The clinician relayed this information to the mother, who provided her son with an age-appropriate, realistic account of the family's finances that laid his fears to rest.

How is it possible that something so simple could work? The reason is that children sometimes develop upsetting misunderstandings that could easily be reassured except that they keep their fears to themselves. Children sometimes tell their counselors about worries that they withhold from their parents. When this happens, therapists should ask the client for permission to share the information, address any concerns that might oppose such sharing, and then bring together the child's need for reassurance with the parents' ability to provide it.

Brent's disruptive behavior in kindergarten did not seem to be the result of complex issues. He was unable to give a description of the experiences leading up to his tantrums, but the teacher's description indicated that the essence of the problem was that he had trouble switching his attention from an enjoyable, independent activity to the teacher's instructions. The first several sessions combined talk about pleasant topics, brief discussions of the problem, and an active game somewhat related to baseball, which resulted in the development of a positive therapeutic relationship. Then, the therapist looked Brent in the eye and said something like this:

"To do well in school, you have to listen to the teacher. You might be having fun with something else but, when the teacher starts talking, you need to have a little bell go off in your mind and then a voice that says, 'Uh oh! Time to listen to the teacher!' If you hear what the teacher has to say, and you do what she says, you won't get in trouble, and you'll do fine in school."

The counselor and Brent then drew a series of cartoon-like pictures that depicted a 4-part sequence of events: (1) Brent was playing a fun game; (2) The teacher began talking to the class; (3) A bell rang in Brent's mind, saying, "Time to listen to the teacher"; and (4) Brent did just that. The pictures helped Brent envision the behavioral sequence he needed to perform in school.

Even this therapeutic work is more complicated than some interventions that occur in child therapy. For example, the fighting between two siblings came to an end when

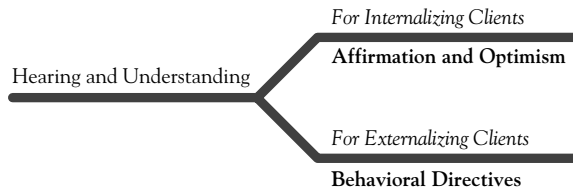


Figure 1.1 Common therapeutic sequences.

the clinician learned that their babysitter confined them to one room so she could watch them while working on the computer; when this arrangement was changed so that the children could play more freely, their boredom and restlessness decreased, their fighting stopped, and therapy was terminated. As this example illustrates, the counselor's goal is not to be brilliant but to help the child.

Much therapy seems to involve the following sequence of events, which is summarized in Figure 1.1. First, there is an airing of the child's problems, and the client comes to believe that the therapist understands these problems, as a result of which the therapist attains *credibility*. Then, there is a fork in the road corresponding to the two basic types of child psychopathology. Internalizing clients make progress when they believe their therapist understands the upsetting, disappointing, or shameful things they have disclosed but thinks well of them, anyway. Externalizing clients make progress when they believe their counselor understands why they misbehave but insists that they change their behavior, nevertheless.

Change processes in therapy might not be qualitatively different from change processes in the rest of life. Children are influenced by adults they like, respect, and view as caring, and clients seem to be influenced by counselors they like, respect, and view as caring. If you can achieve this type of therapist-client relationship, your input will frequently engender change. The chapters to follow provide guidance in how to use this influence for the maximum benefit of clients.

Using Play in Therapy

Play is a broad category of behavior that can be defined as the opposite of work; play is intrinsically motivated behavior with no purpose other than itself. Because play is a freely chosen activity relatively unconstrained by external demands, and because it involves basic cognitive and emotional processes, play is a rich source of information about the child's internal life and personality functioning (Russ, 2004).

Young children have limited language abilities, but they are remarkably able to express emotions, act out concerns, and work through problems using the physical metaphors of play (Erikson, 1950; Gardner, 1993; Russ, 1993). Therapists rely on language to work with adolescents and adults because this is how they represent and process their experiences. Therapists use play along with talk to work with young children because these clients think, imagine, and communicate using physical objects and actions, as well as words.

Structured games such as checkers, card games, and so forth often reveal how the child thinks strategically, competes, and responds to success and failure. However, these structured activities usually provide less fertile ground for the exploration of emotional

In imaginative play, children act out wishes, fears, and beliefs, and their inner life is translated into a public form that counselors can see.

issues than does play involving human or animal figures (e.g., dolls and puppets) in which there is a story with a theme or meaning (e.g., striving for a goal, conflict between two figures). This type of play is based on the process of *pretending*: Children realize the dolls and puppets are just toys but, at the same time, they experience them as animated by human emotions, needs, and goals. In symbolic, imaginative play, children act out wishes, fears, and beliefs related to their experiences and concerns, and their inner life is translated into a public form that counselors can see (Chethik, 2000; A. Freud, 1946b; Kernberg, Chazan, & Normandin, 1998).

Play figures sometimes represent different aspects of the child's self (e.g., her scared, angry, and confident sides). Play figures may also enact behaviors the child has observed in others, thus providing a portrait of her social environment. To interpret the meaning of play, therapists must make educated guesses about which play figures represent aspects of the client and which represent people in her life. For example, an angry monster might depict the client's aggression, or it might represent her fear of powerful, scary adults. Children usually identify with the small, child-like figures in their imaginative dramas, and the large, adult-like figures often represent caregivers, but this is just a tendency, not a rule.

Therapists ask clients questions about their symbolic play as it unfolds. We ask questions about play figures and scenes as if these were external realities that the client knows about, even though, of course, the client just makes up his answers (e.g., "What are the monkeys having for dinner?" "Pizza."). This useful fiction mirrors children's experience of their symbolic play, in which the figures seem to have a life of their own that the child observes rather than controls. Here are examples of questions designed to bring out themes in imaginative play:

- "Where are they going? Who are they looking for? Why are they in such a hurry? What happens next?"
- "The puppy seems so sick—is she going to get better? Is she going to die? Can anyone help her?"
- "Why did the father doll leave? Is he going to come back? Did he get into an argument with the mother doll? Do the children miss him? Do they wish there was something they could do to bring him back?"

The technique of reflection is just as applicable to play as to talk (Axline, 1947). For instance:

- "You're setting up the doll house slowly and carefully."
- "Look at those bears fight! They sure seem mad at each other."
- "The little dinosaur is looking everywhere for his mother; he must be scared he won't find her."

This combination of talk and play creates a connection between the imaginative, magical, and confusing experiences of young children and the more controlled, logical thought processes of adults. The therapist is the bridge between these two domains of experience. The way to do this work is to let yourself be drawn into the rhythm and feel

of the young child's world, where things make emotional sense but not necessarily realistic sense, and little plastic toys come alive and enact archetypical human dramas. Then, cross the bridge back to the realm from which you started; interpret the play using general psychological principles and your knowledge of the client, and utilize this evolving understanding to help the child.

Interpreting imaginative play is difficult because it can reflect different psychological processes at different times. There are three main possibilities. Children depict experiences that they: (1) *expect to happen*, (2) *fear might happen*, and (3) *wish would happen*. For example, a roaring lion might express a client's actual sense of aggressive power; or his fear of being hurt by aggressive people much bigger and stronger than he; or his wish to be more powerful so he could intimidate the people who have intimidated him. (The similar effects of expectations and wishes on perceptions of external stimuli, which make cognitive and motivational processes difficult to distinguish, are discussed again in Chapter 4's sections on projective testing and transference.) Because of these interpretive ambiguities, therapists should not make inferences from small units of play behavior. This type of clinical data should be approached by noting themes, connections, and patterns that emerge over time and should be interpreted cautiously in the context of all the available information about the child.

Children's symbolic play depicts their problems and also their strivings for resolution and gratification. Children seem to set up the situations that distress them in an (unconscious) attempt to master these situations by experimenting with different responses until they find something that, on a symbolic level, works for them (Erikson, 1950; Gardner, 1993). They try out different schemes and strategies, mixing them around until, perhaps, they find one that solves the problem depicted in the play. Sometimes, children are able to translate these symbolic discoveries into behavior in real life. For example, a client experiencing sibling rivalry might enact scenes in which child dolls compete bitterly and angrily for parental nurturance. Over time, the sibling figures might find ways to share their parents' attention in a comfortable way. Then, the client might be able to translate these symbolic solutions into new forms of interaction with his family.

Play, in and of itself, might have therapeutic effects. By expressing difficult emotions, experimenting with options, and practicing coping strategies, children sometimes work out problems on their own through their use of play (Gil, 1991; Russ, 2004). However, if this capability were reliable, children would never need therapy. The play of children with mental health problems often evinces a quality of being "stuck"—the children portray the same distressing themes over and over again, but their dramas are at an impasse, and they do not find solutions to the problems depicted in the play.

This is where the counselor comes in. Play therapy involves more than a child playing while a clinician watches. In this type of therapy, the clinician does something with the play so that it accomplishes more than what it was able to accomplish on its own.

Because play is a medium of expression, not a therapeutic procedure in and of itself, the term "play therapy" specifies no more about the nature of an intervention than does the term "talk therapy." Play therapy can involve several different mechanisms or agents of change. The techniques employed in play therapy depend largely on the theoretical approaches used by the counselor.

One therapeutic mechanism is simply the child's experience of sharing his play, and its associated emotions, with the therapist; if the clinician responds empathically, the child may internalize this accepting attitude toward her own feelings (Axline, 1947;

A. Freud, 1946b; Gil, 1991). Also, by translating the actions of play into language, therapists help clients cognitively process, organize and, perhaps, master the emotional issues acted out in their play (Russ, 1995). For example, describing a scene of fighting and mayhem with words like “Everybody is so *mad* at each other” provides a simple conceptualization that adds a level of organization to the inchoate swirl that the child presented.

Cognitive-behavioral therapy makes use of the “fantasy rehearsal” function of play (Strayhorn, 2002); the clinician uses toys and pretend activities to model the thoughts and behaviors being taught, and the client practices these skills in the context of play (Knell, 1993, 1998). Brent’s therapist used dolls and puppets to enact school scenes and teach him the skill he needed to learn, namely, using self-control to comply with the teacher’s directives. Knell recommends using role reversals to create a variety of modeling and practice opportunities. Accordingly, Brent sometimes played the teacher while the therapist operated the student-puppet and modeled the skill being taught by thinking out loud (e.g., “This game is *fun*—but the teacher is talking now, so I’d better stop and listen to what she says”). Sometimes Brent operated the student-puppet and practiced this skill while the therapist played the teacher; and, sometimes Brent took the role of a peer who coached a distressed student-puppet in self-control and compliance.

In psychodynamic work, therapists use play to learn about the child’s unconscious conflicts and to help her work out resolutions for these conflicts (Erikson, 1950; Fraiberg, 1959; Gardner, 1993). Clinicians can enter the game to enact a symbolic solution that helps the child resolve the problem depicted in the play. To continue with our sibling rivalry example, it might be the therapist who first depicts the brother and sister dolls having fun with their parents *and* each other at the same time, as they enjoy “being a whole family.” If the symbolic resolution clicks for the child on an emotional level, it might produce therapeutic change.

Using Art in Therapy

Art is related to play: Both are imagination-based activities that lend themselves to nonverbal expression of feelings and meanings, and also to experimentation with possibilities. Art is frequently a useful medium of communication in therapy with children, and some adolescents are also comfortable expressing themselves in art.

Artistic activities sometimes get the therapy process going with clients who have trouble expressing themselves in words. Clients’ pictures of themselves may provide information about self-concept. Drawings of the client’s family may reveal information about these relationships. Purely spontaneous drawings are often useful, too. Rubin’s (1984) book, *Child Art Therapy*, discusses a variety of techniques for children and families. Figure 1.2 presents an example of a picture from this book; the picture was drawn by an anxious 6-year-old boy.

Asking questions about the client’s pictures brings out the meanings they express. Counselors might ask why a person who looks angry is mad; or what happened to a tree that looks broken; or why no one wants to play with the little boy shown alone on a playground.

Therapists can ask clients to draw a picture of their problem—whatever that might be. We can ask anxious children to draw pictures of their fears, depressed children to draw their sadness, and aggressive youth to draw their anger. These drawings may provide either concrete or abstract depictions of the issues. Concrete depictions sometimes produce information of practical value. For instance, when a boy experiencing aca-



Figure 1.2 Example of a picture produced in therapy. Source: From *Child Art Therapy*, by J. A. Rubin, 1984, New York: Wiley. Reproduced with permission from John Wiley & Sons, Inc.

demographic problems drew a picture of himself in school, he drew the student sitting next to him as a bully who harassed him while he tried to work. Abstract depictions of problems illuminate the client's internal, subjective experience of her difficulties. For example, anxious clients might depict their fears as terrible, vicious monsters, and depressed children might draw their sadness as a dark, dreary landscape.

Clients can also draw solutions to problems. In its concrete form, this type of exercise might involve a socially isolated girl drawing a picture of herself initiating a conversation with a peer. Brent's therapist guided him in drawing cartoon-like pictures of himself switching from one activity to another in response to a directive from the teacher. Abstract or metaphoric solutions might include an anxious client drawing a picture of a kitten making friends with the monster she had feared, and a depressed child drawing sunbeams and fruit trees into her landscape. Such drawings may not lead directly to real-world solutions, but this type of envisioning often galvanizes the process of change.

Therapeutic Collaborations

Work with Parents

Child treatment should always include some work with parents or guardians. Parents are generally the most important people in their children's lives, and they are the most important element of the formative environments that shape children's development. If the parents' ongoing practices, behaviors, or messages are harmful to the client, 50-minute therapy sessions have only limited capability to undo the negative effects. More commonly, therapeutic work with parents provides an efficient way to bring large benefits to

the client in small amounts of session time. Therapists can spend 15 minutes giving a suggestion or teaching a child management technique that will then be there to help the client every day for the foreseeable future. This is the way to plant a source of help for the child in her home environment.

Parents usually understand their importance in child treatment, but sometimes they do not. Parenting a child with behavioral or emotional problems can be exhausting, and parents sometimes wish they could give responsibility for solving the child's problems to the clinician. However, child therapy is not usually effective when the parent drops the client off at the office and then returns an hour later to pick him up.

One source of parental resistance to therapy participation is anxiety about being blamed for the child's difficulties (Barkley, 1997). This fear seems based largely on an old view that children's mental health problems are always the result of deficient parenting. However, research in developmental psychopathology suggests that child mental health is a complex outcome influenced by genetic factors, socioeconomic variables, life events, peer influences, and parent-child fit, as well as parenting effectiveness (Cicchetti & Rogosch, 1996; Pinker, 2002). Therapists should explain that children are not simply products of the upbringing they receive; they are separate individuals who bring their own temperaments and qualities into families. As a result, many loving, competent parents have children with mental health problems. Counselors can usually recruit parents' active involvement in treatment by emphasizing that their participation is important not because they caused the problems but because they can contribute to solutions. The message is: "I need your help to help your child."

There are five main categories of work with parents. These treatment activities are described in detail in the chapters to follow, and brief descriptions are presented in Table 1.6.

Table 1.6 Types of Work with Parents

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1. *Assessment and monitoring of change:* The clinician utilizes the parent's observations and understanding of the child's everyday functioning. These observations are vital both to the initial assessment and to ongoing monitoring of the child's response to life events and therapeutic interventions.
 2. *Helping parents understand their child:* The therapist identifies reasons for the child's feelings and behavior and then conveys this understanding to the parents. These reasons might be internal to the child—for instance, guilt about a sibling's illness might lead to depression—or external to the child—for example, inconsistent expectations from parents might lead to noncompliant behavior.
 3. *Parent training:* The counselor teaches the caregiver techniques and skills for managing the child's behavior and addressing the child's problems. Examples include teaching the caregiver how to use behavior reinforcement charts and time-out. Parent training is an important aspect of behavioral child therapy.
 4. *Parent guidance:* The therapist offers suggestions and recommendations for the parent to implement with the child. This input is less systematic and more situation-specific than that involved in behavioral skill-training. For example, the counselor might recommend that the parents limit the client's TV-watching and assign him an age-appropriate chore.
 5. *Parent counseling:* The therapist works with the caregiver on her own personal issues related to parenting the client. This type of work might address parental disappointment with the child, the parent's experience of being raised by her parents, and the effects of those experiences on her functioning as a caregiver. (This type of parent work is described in Chapter 7.)
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Supporting the Parent's Position of Authority

Children need their parents to be in charge, and problems develop when caregivers are not in control. Therefore, one core objective of work with parents is to help them establish themselves as authorities in the family (Barkley, Edwards, & Robin, 1999; Henggeler & Borduin, 1990; Sells, 1998). Direct therapist statements such as “You’re in charge,” and “You’re the parent here” may help the parent envision himself in this way. This message can also be conveyed behaviorally, by the way the clinician interacts with the parent. For example, if the child sees snack food in the office and asks the therapist if she can have some, the therapist should turn to the parent and ask whether this would be all right.

One of the reasons parenting is a difficult job is that it elicits emotions like few other experiences, and some emotional reactions disrupt caregiving. The parent’s position of authority is founded on her devotion to the child’s well-being. However, externalizing behaviors frequently cause anger in parents because these behaviors involve disrespect, either explicitly in the form of defiance or implicitly in the form of covert disobedience. When parents strike back at their children with insults and threats, as if they were angry peers hurling hurtful words back and forth, their vindictiveness undermines their authority, because the youth senses that the parent is trying to hurt him, not control, teach, and help him. Yelling is an ineffective child management technique; it should be replaced by clear, consistent rules and consequences.

Therapists should help parents stand above the fray, without their egos on the line, so they can focus on their task of managing and raising the child. One visual image that concretizes this position is that of the parent high on a hill, looking down at the child, stroking her chin and deciding what to do next to facilitate the child’s development. Therapists can sometimes reduce parental anger by reframing the youth’s negative behavior from a purposeful attack on the parent to a result of emotional pressures and skill deficits (see Chapter 6’s discussion of reframing). For example:

“The thing to realize about George is that he doesn’t truly understand what he’s doing. He’s a confused kid, angry and frustrated, thrashing around and making everyone miserable, including himself. The thing to do isn’t to hurt him, though; it’s to help him by teaching him what’s what.”

The distinction between criticism of behavior and criticism of personal characteristics, discussed earlier in this chapter, is just as important for parents as for therapists. One principle of effective child management is to replace negative statements about the child as a person (e.g., “You’re so stubborn,” and “You’re impossible”) with more specific criticisms of the child’s behavior (e.g., “I don’t like it when you disobey me,” and “Running out of class like that was a mistake”). Criticisms of personality are counterproductive because they insult the child and do not provide clear information about what she should do differently the next time. Criticisms of behavior have a legitimate role in both therapy and child management. Thus, parental anger does not need to be eliminated but to be directed against the child’s negative behavior. We will return to this behavior/personality distinction again in Chapter 12’s discussion of communication skills.

One principle of effective child management is to replace negative statements about the child as a person with more specific criticisms of the child’s behavior.

The authority role requires a degree of confidence. When parents interpret their children's problems as an indication of their own failure, debilitating self-blame and helplessness may result. Therapists can sometimes restore parents' sense of hope by saying that, whatever were the original reasons for the genesis of the child's problems, parents can guide their child back onto a positive developmental track by responding effectively to the problems in the present. This view makes it possible to view difficult incidents as opportunities to provide the child with the learning experiences he needs. For instance:

"Children are not born knowing how to behave; they learn this, gradually, as their parents teach them how. And one of the most important opportunities is when kids misbehave. When Celia acts up, I'd like you to ask yourself what you want to teach her by your response to her misbehavior."

For parents, thinking about child development within a long time frame seems to strengthen resilience in the face of stress. Parents all face upsetting moments in the course of their child's growing up; there are times when the child seems terribly distressed, irrational, or dysfunctional in some way. If parents extrapolate from such moments, they may panic at their vision of the future, but linear extrapolation is rarely realistic because, given time and effective help, most youth with problems can traverse the twists and turns of development and emerge, eventually, as successful adults. The message for parents is, "Life is long." Counselors can say:

"Kids make thousands of mistakes as they grow up; in a way, that's their job, because it's part of how they learn. The parent's job is to respond to those mistakes in a helpful, corrective way—day after day, for about 18 years. When the whole thing is over, you'll have a competent adult. So take a breath, because this is a long process."

Collaborating with Other Child-Serving Systems

Children with relatively mild, circumscribed problems usually do not need services beyond psychotherapy. For clients with more complicated problems, therapy should be provided along with other services addressing other needs. Both the problems of childhood and the resources needed to overcome these problems are embedded in social contexts, including family, neighborhood, and peer group, as well as the education, medical, child welfare, and juvenile justice systems. When clients are involved in multiple systems, therapists should collaborate with the professionals in these organizations who work with their client (Henggeler, 1999; Knitzer, 1996).

When clinicians fall into a narrow definition of their work that is bounded by the 50-minute session, their ability to help clients is reduced. There is a practical factor contributing to this limited job definition: Insurance companies typically are willing to pay only for direct contact with clients, so that the consultative work needed for inter-system collaboration usually cannot be billed. Nonetheless, if we understand our job as doing whatever we can to help clients with their mental health problems, we will do this work.

In effective intersystem collaboration, information flows in all directions, and the collaborating organizations enhance each other's work. Psychotherapy is uniquely effective at producing an understanding of the personalities and emotional issues of children. Therefore, counselors who communicate their insights to teachers, pediatricians, child protection workers, and probation officers can enhance the effectiveness of these systems in working with shared clients. For example, therapy might provide information about why a foster child is exhibiting behavior problems in his placement and how the child would be likely to respond to reunification with his biological parent. The therapist should relay this understanding to caseworkers and foster parents so that therapy-based knowledge can be used to enhance the client's placement experience and to make the best possible plans for him. This type of work can be highly efficient in that one phone conversation might result in a major benefit to the client.

In effective intersystem collaboration, information flows in all directions, and the collaborating organizations enhance each other's work.

Information should also flow to therapists from other youth-serving professionals. Input from a pediatrician might help a counselor plan how to help a client cope with a physical disability. Teachers, caseworkers, youth workers, and probation officers often have knowledge that the therapist needs about what the youth is facing in real-world settings and what her behavior is like in these settings. Therapists can use this information to help clients deal more effectively with the challenges they face in school, foster care, and so forth.

Therapists probably collaborate most often with teachers. If the client has either academic or behavioral problems in school, there should be contact between the clinician and school staff. The educators should describe the client's functioning in school so that problems occurring there can be addressed in therapy. Conversely, counselors can often provide teachers with recommendations for helping youngsters in school. For example, a therapist might inform a teacher about an anger management technique the client has learned so that the teacher can coach her in use of the technique when she becomes angry in class. Chapter 2 on behavior therapy and Chapter 10 on disruptive behavior disorders provide additional discussion and recommendations for counselor-teacher collaboration.

Termination

One aspect of treatment planning is determining when therapy is finished. In general, there are two types of situations that make termination appropriate. Sometimes, therapy does not seem to be helping the child. When this occurs, therapists and parents should consider a change of plan, whether use of a new treatment strategy by the same counselor or referral to a new service provider. More frequently, termination becomes appropriate when the client's functioning has shown sufficient improvement. Termination is also sometimes justified by a combination of these two situations: The client's functioning has shown some improvement, with significant problems remaining, but progress has stopped, and the client seems to be on a plateau in which additional work is not producing further change.

How much improvement does a client need to achieve for termination to be warranted? As long as progress continues to be made, counseling should continue until the

child's functioning enters the normal or nonclinical range for her age (unless there is a reason, perhaps a neurological factor, why this goal is not feasible). For treatment goals to be realistic, therapists and parents need to think about the problem levels that typify real children, and these problem levels are considerably greater than zero. All youngsters sometimes feel depressed, behave disobediently, and so forth. If the goal of counseling is a problem-free life for the child, treatment will never end, because therapy is not a cure for life. Termination should occur when the child's difficulties no longer represent a mental health problem but are a matter of the imperfect nature of the human condition. Therapy should end when the parent and youth have the skills necessary to cope with remaining difficulties on their own.

It may be helpful to use standardized measures of emotional and behavioral problems as a tool for determining when counseling should end, but these scores cannot provide the entire basis of a decision because they do not take all of the family's concerns into account. Sometimes, the client's score on a measure is in the nonclinical range but there are still problems that disturb the parents or child. In these cases, the therapist's recommendation regarding continuation of treatment should depend on his assessment of the degree of distress, functional impairment, and possible developmental consequences associated with the remaining problems.

When therapists believe the time for termination is approaching, they should discuss the issue with the parent and child. If there are no objections, a plan should be designed to make the ending comfortable and therapeutic for the client. The usual procedure is to wind down by increasing the time interval between sessions, so the client has an opportunity to prepare and discuss the transition with the clinician. For example, following a course of weekly therapy, the plan might be to see the youth twice more at 2-week intervals and then once more in a month.

Scheduling the termination process in this fashion does not usually work with parents whose use of therapy is crisis-oriented or who are unaccustomed to long-term planning. Once termination is planned, these parents often fail to attend sessions, perhaps because they see no point in doing so if the goals have mostly been achieved. If this seems to be the parent's likely response, it is best to conduct a good-bye session with the child immediately after deciding that the time for termination has arrived.

One important goal of termination sessions is **relapse prevention**, that is, maintenance of gains that have been achieved. There should be a review of past learning in order to prepare for the future. There are two main questions for the client:

- "What did you learn in counseling?"
- "How will you use what you learned in the future?"

Termination is usually a bittersweet experience for children, parents and, sometimes, counselors. When therapy has been effective, children usually have developed feelings of affection and even attachment to the counselor. On the happy side, termination typically occurs because therapy has been successful, which means the youngster's life has improved. This combination of factors sometimes makes termination confusing for children, who may not understand why their success at achieving goals means they must lose a close relationship. Therapists should help clients understand and work through termination in the same way they help clients with other issues—by providing empathy, explanation, and reality-based optimism. For example:

“Your mom brought you to see me because you were having problems doing what she said. Now that you have learned good behavior, we have reached our goal, and you don’t need to come to therapy any more. That is something to be happy about because your mom and I are really proud of you, we hope you are proud of yourself, and things are more fun in your house. At the same time, though, you might feel sad about finishing therapy, because we had a good time together, and it’s sad to say good-bye to someone you like.”

Counselors can use self-disclosure to make it clear that termination involves no element of rejection and to model an adaptive response to therapy’s ending. For example:

“I feel both happy and sad about this, myself. I like playing and talking with you, and I’m sad that we won’t be getting together anymore. But I’m happy that you made such good changes and your life is better now.”

In therapy termination as in grief work, memory provides a means of coping with loss by preserving internalized aspects of the relationship when the person is no longer physically present. Because photographs provide a concrete means of supporting memory, it may be helpful for parents to bring a camera to the termination session and to take a picture of the child and therapist together as a record for the client to keep. Therapists can verbally model the memory process by saying something like:

“I’m going to remember you and the things we talked about, and I hope you always remember me and the things you learned in therapy.”

The idea of graduation provides young clients with a useful way of understanding therapy termination. This concept is familiar to most children, and it integrates several meanings in a gestalt that both acknowledges the sad aspects of termination and highlights its positive side. The idea of graduation means that termination occurs because the child has completed an endeavor. Viewed this way, termination is cause for pride and satisfaction. Therapists can say:

The idea of graduation provides young clients with a useful way of understanding therapy termination.

(Brief review of the client’s progress) . . . “and so your parents and I think it’s time for you to graduate from therapy. It’s like graduating from school: It happens because you’ve learned what you needed to learn from that place, so it’s time to move on to something new. Graduations can be sad because you might miss the people and places you’re leaving behind, and graduations can be happy because they mean you finished a job, you succeeded, and now you’re ready for new things in life.”

With children aged 6 to 12 years or so (and some adolescents, too), it may be useful to create a “diploma” or “graduation certificate” as a tangible symbol of therapy completion. These certificates should be impressive documents with an official quality, because successful termination is an important accomplishment warranting some pomp and circumstance. Diplomas can include brief statements of key elements in the youth’s therapeutic work to support her memory for this material in the future. Figure 1.3 shows an example of a therapy diploma.

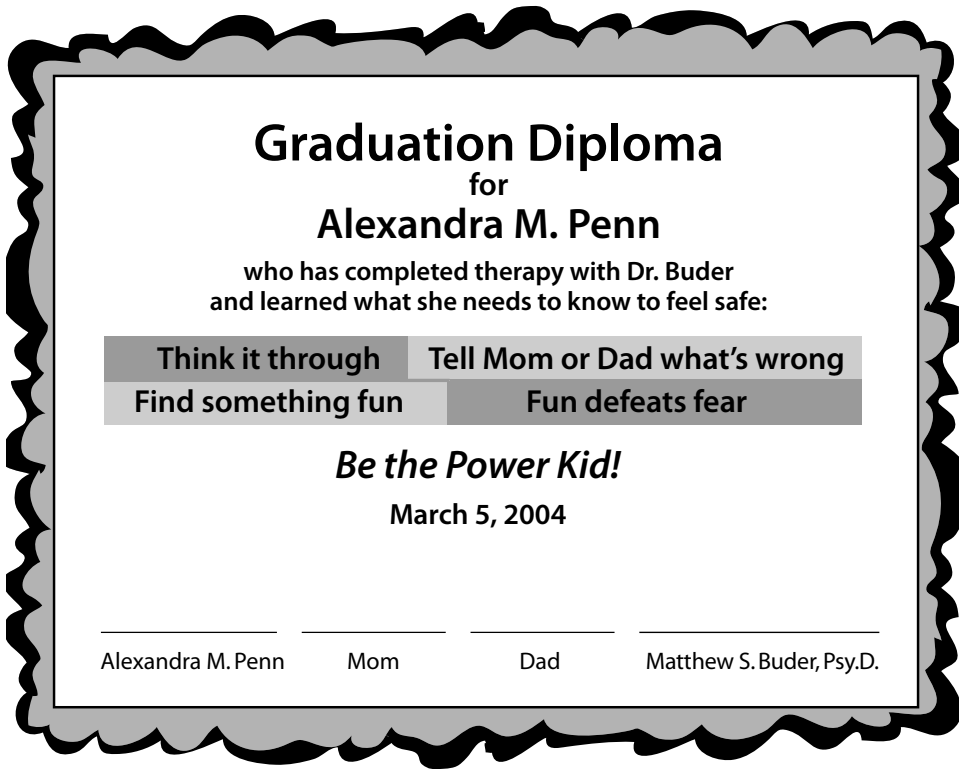


Figure 1.3 Example of a graduation certificate.

Summary

This chapter describes basic features of child and adolescent therapy that characterize most theoretical orientations and apply to most client problems. Generally, therapists can build strong treatment alliances with children and parents by conveying warmth, empathy, expertise, and a commitment to help. Counselors can most effectively engage clients by means of a professional but natural interpersonal style and clear, age-appropriate language.

In their first meeting with parents, counselors should obtain a description of the child's difficulties, answer any questions the parent has about their professional background, and encourage realistic hopes for the child's therapeutic outcome. In their first meeting with children, therapists should provide honest, age-appropriate explanations of the nature of therapy and the parent's purpose in obtaining this service for the child. When youth resist participating in therapy, counselors can encourage buy-in by identifying unsatisfactory aspects of their lives that therapy might improve.

Reflections of feeling and reflections of meaning convey empathy and facilitate self-expression by bringing out the implications of the client's statements. Clarifying the nature of the client's problems, setting specific objectives, and encouraging the client to monitor her progress organize her efforts toward therapeutic goals.

Although problem etiologies and therapeutic strategies are often complex, simple interventions sometimes help clients in direct, immediate ways. Some therapy sessions

involve a sequence in which, first, the parent identifies a problem to the counselor and, then, the counselor and youth develop a plan to resolve the problem. When practical, a summary of these problem-solving efforts should be preserved in writing to support the client's memory for the plan.

Sometimes, a more indirect approach is needed to uncover and address the emotions and misunderstandings responsible for the client's disturbance. Especially with young children, play and art may supplement language as a medium of thought and communication.

Child therapy generally involves work with parents. Therapists can support parents in their authority role by facilitating the self-confidence and devotion to the child's well-being that this role requires. Thus, discipline should be oriented toward teaching the child the lessons she needs to learn, rather than striking back in anger.

Therapists collaborate with other professionals to coordinate the care of clients involved in multiple systems. If they share insights and suggestions, professionals in the mental health, medical, education, child protection, and juvenile justice systems can enhance each other's work.

When the therapist-client relationship is positive, termination may be a bittersweet experience, because it is caused by the achievement of a goal but its effect is the end of a valued relationship. The idea of graduation provides an accurate, empowering metaphor for termination. Therapy diplomas that affirm the child's accomplishments and encapsulate a few key therapeutic points provide a means of preserving memories and carrying their beneficial effects forward into the future.

Case Study

The simple, directive intervention provided by Brent's therapist proved to be what this child needed to solve his problem. The episodes of noncompliance and tantrums in school came to an end. As a result of his previous misbehavior, Brent had to contend with some teasing from classmates who predicted that he would get in trouble just as he had in the past. The teacher overheard his retort: "Dr. Shapiro said that if I listen to the teacher I'll do *fine* in school."

Brent sometimes expressed sadness and confusion about his infrequent contact with his father. However, because this concern did not seem to affect his overall functioning, it did not seem necessary to make a therapeutic issue of it.

Because Brent did not read, he did not get a written certificate, but he received a therapy diploma in picture form. His therapist drew a smiling Brent looking happy in school, with a scribbled representation of words traveling from the teacher's mouth into the child's ear.
