Part I

The Essentials
Beginnings are important, arguably critical. A small misstep can detour us unnecessarily; a large enough one can wholly derail the journey. At the very least, the first steps, the ones from which all other steps follow, form the foundation on which a therapy and the essential relationship within are built.

We begin with the parents. They are the ones who usually choose, arrange, and pay for a child’s psychotherapy. Consider the challenge facing the mothers and fathers who call us. In a handful of minutes, they try their best to present an enormously complicated, painful, and often embarrassing situation to a complete stranger who purports to be some kind of expert on matters of children and families. As former students, we know the intellectual demand of case formulation. Imagine adding the heavy measure of worry, self-blame, and hopelessness that parents feel.¹

Whatever parents’ issues, we try to listen patiently. If we’re rushed, we say so and offer a better time in the near future to talk. Sensitized to
the difficulty of their call, we try to help parents tell their story—asking helpful questions of the timid, slowing the speedy, organizing the rambling. We do so not only to foster a connection but also to see what the problem is and whether it is one that we can help solve.

A few more moments on the phone can convince us that we are not the appropriate clinician and might inform our making an effective referral elsewhere. Or they can help us to distinguish true crises from entitled demands or reveal the basic motive for the call (e.g., seeking not therapy for the child but evidence to battle for custody). Our time is well spent on the first call and is in everyone’s best interest. It preserves our hours to do treatment. It saves the patient’s time and money, and, by helping get the child to the right help and person, it can prevent the emotional toll of prematurely investing in the wrong therapist.

When sensing a mismatch, we gently—so as to minimize any feelings of rejection—describe how children, particularly adolescents, tend to connect most with the therapist they see first. Meeting with us, we further explain, could obstruct connecting with a second therapist. For many parents and children, meeting a therapist and sharing their stories is both draining and bonding. It is almost always best to save the powerful early meetings for the therapist of final destination (though sometimes clinical conditions or the restraints of health care systems require patients to see a series of practitioners on the way to their eventual clinician).

While we assess matters, so do parents. In many instances, they shop for a therapist even as we speak. What do parents look for? All sorts of things. Facts, such as what we do, what we charge, what kinds of insurance we accept, whether we have openings, where the office is. Do we listen and seem to care? Do we sound kindly and patient?

Many parents have begun to form impressions of us even before hearing our voices. If we’ve come highly recommended, there may be halos around our heads. While inflated views of what we can do make for easier and enthusiastic beginnings, they can just as often backfire, leading to disappointment and impatience, even premature endings, when our work does not produce big enough or fast enough results.

Conversely—and more commonly in today’s busy and tight marketplace—parents consult us because of insurance plan constraints or matters of distance and scheduling. To one disgruntled mother who saw me as her distant second choice, I said, “You’ve mentioned several times having to stick to a list of providers.” Putting such dissatisfaction on the table helped her to
speak her mind concerning her ultimate doubt as to whether any therapist could help. Sharing this thought with me gave her a bit more confidence in the process and led to her giving me a fair chance to prove myself with her and her daughter.

I see the purpose of the initial call as deciding whether future contact with me is likely to benefit the child. If it makes sense that we go no further, I aspire to give parents a good experience with me as representative of the mental health profession so that they will persist in their quest for help. And when we do agree to meet in person, this call has gotten us off on surer footing, the work well begun.

**FIRST MEETINGS**

With younger children, I typically offer parents the option of meeting with me first without their child. This provides an opportunity for the parents to speak freely and check me out. I suggest that parents of elementary school children accompany their child. In contrast, I urge parents to let their teenage children come to the beginning hour by themselves, explaining that doing so counters the common adolescent tendency to mistrust and reject the therapist as another arm of parental authority. I bend, however, to comply with parents’ good reasons for other arrangements (e.g., a ninth-grade girl who fears going anywhere without her mother or including a very young sibling who can’t be left alone in the waiting room). Regardless of the child’s age, in the course of the initial meetings I try to meet with both child and parents, alone and together. This early negotiating, structuring, and educating concerning who should come begins to show parents how therapy will work and proceed.

Making our patients feel safe—the absolute first requisite to any worthwhile course of therapy—begins in the earliest moments. Do we take a minute to greet everyone who has come with the child? Are we kindly? Do we smile sincerely? Do we look the child and his mother in the eye? Or do we appear to be just doing a job, grudgingly serving the next customer? Do we ask how they’re doing, then turn away and head into the office before they’ve answered? Giving a disorganized mother a few minutes to gather her children and their belongings may accomplish more than rushing her into the office. By themselves insufficient to ensure good treatment, these civilities—done in good measure, neither
to feign sympathy nor to manipulate—convey a sense of us as real persons and help our patients make the transition to the world of therapy they’re about to enter.

When we go out to meet new child patients, some zip past us like Speedy Gonzalez, rifling through our toy boxes or our desks before we’ve said hello. A majority of them follow the lead of their parents who, in turn, follow ours. Others dally, coming at a snail’s pace out of fear or to show who’s boss.

Sure that I, at this point, am sure of little, I tend to stay out of the line of fire. I let parents and child struggle their way into the office, reminding myself that they somehow manage their lives when I am not around. I do not force anyone to come in, for that is the quickest way to nowhere. My threats or tugs may get a reluctant child inside today, but there’s a good chance he won’t return tomorrow. And even if the child returns, she will see me as someone to be mistrusted, someone who has little respect for what she wants and does. Frustrating as it is, we generally can’t hurry what must come in its own time.

I can’t recall one instance when I’ve denied a child’s wish to come in with or without someone. Soon after we settle in, however, I turn our attention to the reasons for the demand, leading to a readjusting of who should and shouldn’t be there. While I never force a child to separate from a parent, I do note the desperate nature of her fear, a fear that will quickly take center stage in her therapy.

When parents can’t get a child to even come to the waiting room, I spend my time consulting with them, helping them to better understand and manage their child. Anything but a waste, such sessions prove to be at least as valuable as if the child had come (which usually happens the following week).

Once in the office, I say hello again. Children seem to appreciate this and sense that, under their parents’ and my watchful eyes, they hadn’t had a good chance to meet me. After a minute of quiet, an awful lot of children will spontaneously comment on what happened in the waiting room—the confusion, the nagging, the sibling riot—shedding light on their thinking and family dynamics. My simple interest in these observations goes further than any proclamations I might make to show my accepting attitude. The actual words, “You can say anything you want in here,” however exuberantly stated, have in themselves convinced very few children to spill the beans.
For the first minutes of our hour, I allow children to do as they wish. Some children calmly survey the place before taking aim at a particular object or toy. Some go right to my desk and begin drawing or ask if they may. Some come close; some stay as far away as they can. Nontherapists may be surprised to learn that many children sit in the chair opposite mine and begin talking of their troubles or wait for me to ask about them.

By this time, children tend to take notice of the office. Is it a place for children? This, perhaps, is the first question our child patients try to answer for themselves. Children from almost any background and class seem to prefer comfortable, cozy, and unpretentious. They prefer offices that look more like living rooms than hospital suites. Children tend to pick cluttered over immaculate, assuming that they will not be expected to be as neat in their play (and maybe even in their thoughts). And as we all know, a good selection of toys, building and drawing materials, and the like can be the quickest route to making children feel welcome (though, to be sure, it takes a lot more than cool stuff to earn their confidence).

Children will look around in an attempt to learn about the therapist. Fine furniture and original oil paintings will certainly give a different impression than ripped posters put out by the dairy council or drug companies. Happy childish pictures of sleeping bunnies and dogs dressed in people’s clothes may entertain but give a much different impression than more sedate and ambiguous pictures of roads winding into the woods or a lone bird flying into a muted seascape. Too many diplomas may impress one child, make a second feel inferior, and lead a third to perceptively wonder about the therapist’s insecurity. Children begin to read into what they see, but most of the time will keep it to themselves in the first hour, over time testing their hypotheses against the real thing, the therapist.

Of course, many child therapists don’t have their own offices. They, as students or as practitioners in a crowded clinic, use whatever room is available, however poorly kept or offensively decorated. Other therapists do their work on the road, hauling a bag of toys to schools and shelters. These therapists know best what the rest of us learn soon enough, that over the long haul it is our psychological presence, not our furnishings or things, that most matter to patients.

To learn and be able to help all we can, we need children and their parents to talk as openly as possible. To talk they must be comfortable. How do we accomplish that?
We might actively seduce them, by permitting them to sit on the windowsills, offering soda and chips, whatever the hour. We might alleviate the slightest hint of tension, theirs or ours, by laughing robustly at things that do not strike us as funny or that are unusually perverted. Likewise, we can compliment their parents’ choice of clothes or disclose that we, too, have children who wet their beds or disobey us. But these methods carry risk. Children and parents may get the wrong idea of what we do, thinking that we are there to appease them rather than to help them confront their demons and troubles.

Giving good ear is the earliest and most powerful method we have to engage parents and children. By *good ear*, I mean listening that is attentive and caring, listening that truly wants to hear what is being said, not that wants mostly to get another question and interview out of the way. While patients’ words inevitably evoke thoughts and feelings in us, we cannot really listen while planning our next question. Some of us nod and others “ahem” in understanding. But it is the substance of our listening that underlies these signs, the where and how it leads us, that shows parents and children that we are there and interested.

We may have a million questions; we ask a limited number. We ask them slowly. No one likes a third degree, even those who deserve interrogation. Too many questions can shut down the most open and cooperative of us. A handful of open-ended questions answered fully and with ample reflection and interaction will, on the average, inform us more than a lengthy laundry list of items to be asked and responded to Dragnet style.

We go cautiously and remind ourselves that not every piece of information is an invitation for further probing. Patients will often tell more than they wish to and more than they are comfortable with. Learning who our patients are takes time and cannot be jammed into one, two, or even three sessions (even if mandated so by a health care insurer).

Knowing also means knowing when we don’t know. On hearing of a dead grandfather, I’ve made the mistake of inferring sadness and regret, later learning from an embarrassed teenager that, in fact, she was glad that “that son of a bitch” had died, a pillar of his community who’d abused his daughter, my patient’s mother. I don’t assume to know what anything means to another person I’m just meeting. “Why,” I’ll ask a parent, “do you think Ben (a seventh grader) is so worried about getting into college now?” Or, “Why, of all the different issues you’ve raised, are
you most upset about Joan’s not being more popular?” “What’s making you cry?” I’ll softly ask a child who weeps. And when she says, “I don’t know,” I may gently wonder aloud whether she is sure that she really doesn’t. Those I ask are often surprised that I question matters or behaviors that tend to be taken at face value. Their varied and unexpected answers confirm the wisdom of my inquiring.

Although we may not like what we are told, our job is neither to judge nor to criticize. We can take for granted that our parents and child patients have already gotten a lifetime’s worth of judgment and to little avail. Experiencing our respect for their lifestyle, they—the ones who sought us—frequently will reveal on their own what they think to be amiss or at fault. By respect, I mean appreciation of the meaning and value that certain life decisions have had for others. I mean neither enthusiastic praise nor tacit endorsement, for it is quite possible that sooner or later I will help parents see why some of their choices have been harmful or deterring to their child—and maybe to themselves. Similarly, we must respect the love that a child has for her parents and families, however abusive or mistreating. To neglect or unilaterally dismiss that love or relationship is to neglect the child.

Our neutrality toward interpersonal conflicts as well as those within the child centers our compass so we can position ourselves to best see all that transpires. I am repulsed, for instance, when a young boy describes torturing animals. But I know that my moral censure will only send this child away to hurt more animals—and perhaps people, including himself. Listening to the gory details and slowly discovering the hurts and injuries that lead to his need for cruel power are, relatively speaking, the surest key to helping him stop his wayward sadism.

Similarly, when I observe a boy and his father wrestle, I do not take sides. My hunches about who is most right almost always prove to be wrong in the long run. Besides, it really does take two to tango, even when the two are parent and child. Our clear role is to aid both parties to assume responsibility for their contribution, whether 5 percent or 95.

Fearing criticism and not knowing what to expect, parents and their children may be quite nervous when they come to meet us. Often, just seeing that we are regular people and that our offices have chairs and lamps and wallpaper—not medical machinery or rubber pads—can moderate that anxiety. Managing the tension that remains or that is made anew in response to our interviewing is another major way to foster comfort.
We don’t want our patients to feel too stressed to speak and think or so ill at ease with the process that they abandon therapy before it begins. Nor do we want patients to feel so relaxed they lose the impetus to do the work that therapy requires. Overly successful attempts to reduce patients’ stress can make for easier sessions but can risk letting parents and children leave feeling as alone with their problems as when they came.

How do we concretely manage tension? We watch and observe patients’ reactions to the interview setting and our comments. Unless we know how to see anxiety, we can do little to handle it. In some children, it’s easy to see. They visibly shake and sweat, squirm in their seats, put bracelets on and take them off, or pick their noses. Some talk at the speed of light, compulsively interrupt us and themselves, and overflow with a cascade of worry.

Tension can be harder to detect in others. It can hide behind seemingly self-composed personas that are more guarded than confident. Or it can be the motive pushing more aggressive parents to confront us about our credentials or skills before we, so they fear, can attack them first. Likewise, children who seem to want little to do with us may be revealing, not so much an active rejection of us, but a morbid fear of people.

We seldom remark directly on a nervous habit for that can make patients feel criticized and self-conscious and take away an outlet for their tension. But noting the enormity of their anxiety—“You’re holding so much worry”—in words that connote the painful burden of being a worrier can help. Overtly nervous children respond to calm and steadiness and even humor concerning their plight. We do not falsely reassure, telling them that they or their loved ones will never die, for that does not reassure and mostly makes us seem like fools.

We go slowly with patients whose anxiety is withdrawn or disguised. When children physically step back, we do not step forward or even lean forward. Their retreat is for good and deep reason. We do not force eye contact. Or should a child be fortressed in his winter coat, we do not rush to invite him to take it off. We assume he feels better with his coat on. When children psychically withdraw, we honor that too, letting their neglect of our questions go for now.

As therapists, our flexible use of structure and freedom helps to create a sense of safety. I find that a majority of patients, children and parents,
do best with a relatively open-ended atmosphere that, while mindful of
the information I need to know, follows their lead. This is not as true
for others. The freedom to do or say as they wish can immobilize some
anxious and inhibited patients. They prefer guidance as to where to sit,
what to talk about, how to play. Rambunctious and impulsive patients
are bolstered by greater structure and sharp limits.

Depressive children and parents may have other requisites for com-
fort and safety. They need therapists who can tolerate great sadness and
despair, even this early in the relationship. The glib cheer of a Pollyanna
will leave them untouched and awash. They need therapists who take
their pain and hopelessness seriously without falling prey to their gloomy
outlook. Such patients require enough silence in the hour for their hurts
and passivity to surface.

Narcissistic children and parents have especially strong needs not to
feel flawed or lacking. Just coming to see a therapist can feel like a fron-
tal assault to the esteem of narcissistically fragile people. We take great
care to note the courage—and for parents the great love, too—implicit
in their coming for help. We tiptoe, not out of fear but to prevent sud-
den and disruptive deflating of a self-image that, however large, is quite
shaky. When they ask unusual or abundant questions about our qualifi-
cations, we answer straightforwardly and nondefensively. We hold these
children and parents with great care lest they drop, break, and flee the
shame of therapy.

And then there are the angry parents and children who have come
with great ambivalence or against their will, under the pressure of a
spouse, school, or court. Sometimes simply acknowledging and accept-
ing their reluctant presence defuses the anger and allows the interview to
proceed smoothly. Others may be comforted and put into a manageable
place by our clear stance that we will not be mistreated.

Both parents and children appreciate our sincere interest in their story,
in knowing why they have come. “The school says that Joey has ADD.
But what do you think?” I ask a parent, my question paying homage to the
importance of their opinion of their child and suggesting that they will be
expected to participate. From child to mother to father I go, asking each
for his or her version, inviting each to critique or confirm the others’ view,
trying to find the discrepancies and announce the truths that always lie in
the middle. “Joey, you’re telling me that you can get so wild it scares you.
And your parents are telling me that they’ve been getting on your back,
sometimes even being mean, because they don’t know what to do when you get that wild. Is that something you all would like help with?” Stated matter-of-factly and in their own terms, parents and child appreciate clear summaries of the reasons they’ve come.

Our valuing free expression will show itself early and clearly. Unlike what occurs with many other authorities in their lives, children are pleasantly surprised and sometimes bemused to see that they can say whatever they like, however they like. Whether it’s about sex, aggression, greed, or silliness, they discover that it’s okay in here. They can put down their teachers, their parents, and even me without being punished or retaliated against. They soon see that our only revenge is to gently wonder what experiences might account for their feelings and opinions.

When a young girl stammers to tell her side of the story to a bullying parent, I hold my finger to my lips, shushing the parent to let the child speak. I am no less protective of a devoted mother whose teenage and somewhat abusing son cuts her off at every word. My interruptions are meant not to ridicule or control but to facilitate talking. Both parents and children start to learn what therapy and I am about.

Although therapists have an agenda, meaning certain things we want to know, we are bound to it loosely. We follow the lead of the children and parents, the ones who live their lives firsthand. Their conscious and unconscious know the quickest shortcuts as well as the most telling detours around the issues and pains that bring them here. Our overactivity—too many questions, too many what-abouts, too many changed subjects—will likely distract us and our patients from the matters at hand and in their hearts.

These generic ways of being with children and their parents in the first meetings give them something immediate and tangible to know about us and therapy, begin to forge a sense of trust and relationship, and promote our gathering the information we need to more formally plan and offer treatment.

NOTES

1. Frederick Allen (1964) makes clear that, whatever the circumstances, parents’ bringing their child for help is a “first step of prime importance for them” (p. 101). Allen aptly stresses the unique and intense experience that the first meeting evokes for both children and their parents. His enlightening
chapter can be found in *Child Psychotherapy*, a book edited by Mary Haworth. Its list of contributing authors—Erik Erikson, Virginia Axline, Eveoleen Rexford, Clark Moustakas, Melanie Klein, Haim Ginott, Jessie Taft, Anna Freud, Selma Fraiberg, and so on—reads like a Who’s Who of child psychotherapy. The rich, useful, and brief pieces in Haworth’s compilation remain highly relevant to today’s therapists. They also give a good sense of the history and state of the field in the 1960s.

2. Students and trainees will especially appreciate the chapter by Shapiro, Friedberg, and Bardenstein (2006) on therapy fundamentals. They offer valuable and concrete suggestions on ways to meet and talk with the child and parents. See also Anna Freud’s discussion on introducing treatment to the child (Sandler, Kennedy, & Tyson, 1980, pp. 153–157) and Reisman’s (1973) chapter “Meeting the Child” (pp. 121–156).