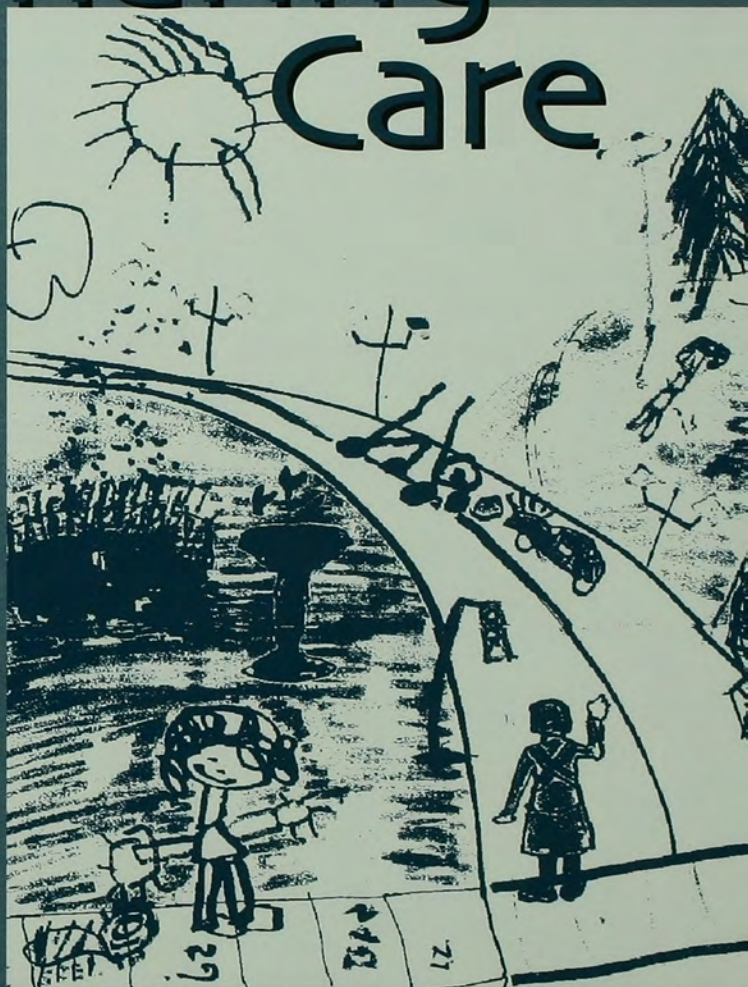
THE INTEGRATION OF FAMILY APPROACHES WITH CHILD TREATMENT

Sharing Care



Robert G. Ziegler
with Andrew H. Bush

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The Integration of Family Approaches with Child Treatment

By

Robert G. Ziegler, M.D.
with **Andrew H. Bush, M.D.**

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Dedication

This book is dedicated to
the past and present
Adult Residents and Child Fellows

in training at the
Department of Psychiatry
at The Cambridge Hospital
Harvard Medical School

who ask too many good questions to be ignored

and the staff, personnel, and faculty at
The Cambridge Health Alliance
who have made a place
for those children and families in need of care.

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PREFACE

"I think my 6-year-old daughter hates me."

"My 15-year-old son has been in a juvenile detention center for three months and he is losing weight. I think he has a brain tumor. He is supposed to go before the judge next week."

"My 5-year-old son's poops have started leaking out of his pullups onto our living room rug. If I thought I would have to put up with poop on the rug, I would have gotten a dog. What can you do to stop him? Nothing we have done works."

"My 17-year-old son has terrible acne and is getting depressed. He actually said he wanted to talk with someone."

"My 5-and-a-half-year-old has been getting more and more anxious over the past eight months. He can't leave for school without crying; he can't go to the bathroom at school without his teacher going with him. He says he remembers when he wasn't worried all the time."

"My 16-year-old son is selling drugs and the housing authority said that if he didn't get treatment we would be evicted. Could you come in disguise? He runs away when we say we are going to bring him to see someone."

"We just saw a television program about attention disorders and we are worried that our 9-year-old son has that. Can you help us?"

"My 8-year-old daughter told her school counselor that her stepfather was abusing her after he grounded her, and now the Department of Social Services is in our life. Can you help us get them out?"

"My 8-year-old son doesn't listen to me, and it doesn't even matter when I whop him."

"The teacher said our son in second grade was slow and that he couldn't pay attention. We think he is fine, but the school said we had to have an evaluation. He's no worse than the other five we have—we think the teacher doesn't like him."

"When my son started fifth grade, his face just started jumping around and now he clears his throat all the time. The pediatrician told us to give it time, but we are still worried."

"My daughter is still having long temper tantrums and she is 6 years old. I'm a single mother who has to work and she just got suspended from her after-school program."

"Adjani's father died last year in Brazil so we had to bring him here. He won't go to school and says he misses being able to be in the bars at night. He told his aunt he had a 25-year-old boyfriend there."

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"My son just got caught stealing from a department store. It is right before his bar mitzvah and he says he doesn't even care."

"Our 8-year-old son told us that he is hearing a voice that tells him to do bad things. He is always in trouble."

"Our 15-year-old daughter took an overdose and is getting discharged from the hospital in two days. Our insurance company said you were on our list."

This is just a small sample of the calls for help that can come across a child/adolescent and family therapist's desk in the course of a month. Each one raises different questions or fears in the mind of the therapist. Each call requires evaluating the child, the parents, and how they work together as a family unit. Information from home and school as well as medical, family, and developmental histories will need to be considered in a full assessment. Part I of this book will focus on a way to gather and integrate these multiple points of view. Chapters 1 and 2 will review some of the tools, techniques, and concepts that clinicians can use in the process of assessing the presenting dilemma. Four zones will be defined that represent the level of function in child, parent, and family. Each of these zones of care will lead to a specific approach to treatment. Part II will focus on the treatment of the current *DSM-IV* internalizing and externalizing disorders in children and adolescents and their treatment. The initial steps in either treatment plan will be reviewed in chapters 5 and 6. Short-term approaches (fewer than 20 sessions for child, parent, and family) will be reviewed as well as what some of the current literature suggests about implications for continuing care (one to two years). Issues of longer term care (over the course of years) will be discussed in Chapter 8. Guidelines will be offered to assist the clinician in identifying the various elements of care that lead to stabilization for children and families over the course of the child's development.

Throughout the text, the authors have attempted to develop useful clinical vignettes made up from a composite of their treatment experiences. Most clinical examples do not represent one child, adolescent, parent, or family, but are a creative blend of various clinical encounters drawn from practice over many years.

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ACKNOWLEDGMENTS

The evolution of this text has been drawn from years of practice, teaching, and supervision. The first author has seen the extraordinary change that can be achieved in a single session, as well as the slow painful growth that has occured in some who manage the extraordinary impact of mental illness, adverse life experiences, or character problems. There have also been cases in which the way to make a helpful contribution was never clear. Even with the increased availability of new techniques and psychopharmacological options, I have never found a single silver bullet. The most powerful tool for treatment, in my opinion, has been a plan of care that enhances an individual's or family's recognition of their own strengths and patterns of coping, coupled with their sense of being understood.

This book was written with Andrew Bush, M.D. He has helped me understand how best to be clear about the various steps I have advocated in both diagnostic and treatment phases. He has helped me focus on the most common concerns that may come to the mind of the new therapist in facing the types of problems that are discussed here. His careful point of view, as a child psychiatrist who is both a child and family therapist, has made this work more readable and has challenged me to clarify the overall principles I wished to describe.

Dr. Ziegler is grateful to Drs. Giuseppe Erba and Valeria Cavazutti who conveyed the similarly complex issues in contemporary pediatric and adolescent neurology and neuropsychiatry during our years shared in the Division of Neurology at Children's Hospital, Boston. In this setting the uneasy hope for a silver bullet from another field was seen as what all clinicians and parents wish for—an easy answer. This is not available. My wife, Patricia Ziegler, who is a talented and pioneering psychotherapist and whose groundbreaking work in the treatment of borderline disorders at The Cambridge Hospital, Cambridge, MA, offered me the courage to value "plain speak" (rather than indirect metaphoric allusion) and cognitive–behavioral perspectives when they were still rarely used in treatment. Our daughter, Lisa, pushed the work along on this volume by helping to finish a number of details while always respecting and encouraging me; our son, Jeffrey, provided some needed humor and sense of perspective to make sure this book did not atomize family life.

All of my colleagues, past and present, at Boundaries Therapy Center in Acton, Massachusetts, where I have treated children, adolescents, parents, families, and adults for over 25 years, have been invaluable clinical resources and sources of friendship and support. These include Marc Berman, Bonnie Broe, Mady Drucker,

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Andrew Bush would like to thank all of the teachers and role models who have offered so much along the way: Hugh Leightman and Harry Parad, for their dedication and generosity as codirectors of Wediko Children's Services, Boston, where Andrew worked as a child care worker; Petra Hesse, who provided an introduction to developmental psychology and who fanned the flames of an inquisitive spirit; Ed Mason, for the opportunity he provided to explore the world of documentary filmmaking; Shevert Frazier, for his warmth, infectious enthusiasm, and breadth of interest, which led to Andrew's decision to apply to medical school; Bob Waldinger and Pam Peck, who supported and encouraged Andrew during his early years in residency; Tim Dugan, who stood firm through some periods of doubt; Carter Umbarger, for an introduction to family systems work and his willingness to listen; Neal and Vicky Kass, who reminded Andrew of who he was and what he could be; and, of course, Bob Ziegler, who through his openness to hearing what another thought of his work was able to make this collaboration possible and for the friendship that grew out of the work. Most importantly, Andrew would like to acknowledge the help and support of his wife, Ruth Faas, with whom he has learned what matters most about raising children.

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INTRODUCTION

The Foundation of Psychotherapeutic Care: Relationship and Knowledge

Although there is no one formulaic response that can address the complex questions that a clinician must consider in the care of children, adolescents, and families, this text is oriented toward helping the clinician use his or her resources in the most effective manner possible. Ultimately, therapists must exercise their clinical judgment, which has been shaped by training and experience. The text will emphasize that all treatments should be informed by the use of the bedrock of child and family practice: relationship and knowledge. These two elements are the foundation for all good psychotherapeutic work. Relationship to all members of the family will be stressed as a key element of care as well as current knowledge of child, adolescent, parent and family function and disorders.

Relationship is, to this day, one of the most effective psychobiological/neurobiological tools that is available in the therapeutic armamentarium of care. Relationship bathes and protects the central nervous system from the toxic stresses of everyday life, which have their own neurobiological components. Just as parents who are well attuned to the needs of their infant can help settle distress, well trained psychotherapists use attunement to form relationships with child and family, which will facilitate every intervention undertaken. Since all child treatment rests upon the foundation of the strength of family relationships, the therapist must routinely strengthen and enhance the ties between child, parents, and family in all phases of assessment and treatment.

To care for a child patient is to care for all family members involved in caring for the child; the therapist will focus on *Sharing Care*. The therapist will be helping parent and family best respond to the child's needs. The therapist must form an alliance with all members of the family and consider their needs for care as well. In the more severe cases, the care will be shared, not just by the family, but by agencies, state protective services, and schools. Multiple therapists may have to develop a shared plan of care.

In most cases, however, the therapist will be sharing the care with the family. In this era of managing care, the therapist must actively choose—among the competing needs and feelings of the child, parent, and the family as a whole—how to allocate the available resources (number of sessions and time within each session) to best address the problem to develop new family-based solutions. On top

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of that, the therapist must foster the positive aspects of the relationships within the family for the child to truly continue to heal. From patterns of compliance to the impact of pharmacotherapy, well-attuned relationships with all members of the family will enhance outcome. The therapist must understand, explore, and tolerate his or her own feelings and the complexities of relationships with the children and their families.

When therapists create a context in which family members can truly express and discuss their feelings toward each other, these exchanges lay the groundwork for the process of acceptance among family members as well as between therapist and family. Acceptance is a core psychotherapeutic component in establishing relationship and in developing the treatment alliance. The more the therapist struggles with being able to accept all of the family members, or feels imbalanced on the pathway of the care plan, the more this sense of risk is diagnostic. The relational stability among family members that is the foundation for most therapeutic interventions is not there. The therapist may have to reevaluate his or her expectations for the treatments.

In addition to relational sensitivity, there is a base of knowledge that child and family therapists draw upon. It comes from multiple fields of study. From developmental research and current diagnostic definitions, to an understanding of parental functioning and adult psychopathology, to a sensitivity and orientation to the principles of systems- and family-based practice, each component of a therapist's prior education and training may be utilized at some point in an intervention with children and families. This process can be an overwhelming task for a therapist, particularly in these pressured times. This book is designed to help a therapist continue to develop a comprehensive and integrated model of assessment and care that will lend itself to the further refinements expected by the explosion of knowledge in the various fields that influence child and family therapeutic practice.

The confidence that therapists have in the level of their knowledge interacts with the therapeutic relationship. Since the impact and stabilizing effect of therapeutic work rely upon the introduction of a calming influence (the therapist) into the entire system, therapists must feel settled with the plan of care that they develop. Thus, a therapist's countertransferential uncertainties can undermine the capacity to be a stabilizing and modulating influence in the life of the child and the family. The approach developed here will help therapists feel more secure with the various elements of their assessment and treatment plan. It asks the therapist to address as soon as possible potential complications to care. As the treatment unfolds, the therapist's knowledge of the various components of the problem will evolve along with that of the family.

☐ The Initial Assessment: Setting the Stage for Treatment

The assessment of the child or adolescent, the parents, and the way the family functions as a whole will lead to the development of a treatment plan that can be shared with all of the family members, separately and then together. Each person must understand his or her part in the problem and his or her role in the solution.

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The child must know that the problem does not mean "I am bad." The parents must hear how their skills as parents, their emotional resources (with their pluses and minuses), and their connection to the child can help the child master the dilemma embodied in the presenting problem.

The family must be encouraged by the therapist to recognize that they, as a productive team, can work together to feel better. The fundamentally positive connections between parent and child must be strengthened. In the most difficult instances, the therapist must balance the treatment plan on the high wire of the family's declared (and undeclared) tensions, which interfere with the child's and parent's use of their natural abilities to resolve the presenting difficulties. Then the therapist must find out what resources can be used to find solutions.

The assessment of the presenting dilemma should lead to the therapist's understanding of the child, the parents, and the way the family interacts. The resulting diagnostic formulation, when presented to the family, buffered by the therapeutic relationship developed in the initial phase, lays the groundwork for the treatment plan. The relationship with the therapist will help both child and parents bear the pain of looking at, for example, family relationships that need attention or the presence of an anxiety disorder in parent or child, even when this news is not wanted.

Handling this highly charged negotiation depends upon the development of trust between clinician and family. This trust must be built on the therapist's honest feedback about the difficulties that are defined within each segment of the family. The alliance with the child must be developed, while acknowledging the child's "mistakes" or identifying areas of growth that must be addressed. The role of the parental assessment, the focus of chapter 3, should enhance the parental alliance. At the same time, the assessment will define the nature of the work the parent needs to do for the child. When an aspect of parental psychopathology (the parents' "mistakes") is uncovered that bears on this work, the therapeutic relationship should help the parents understand that their own treatment may be necessary. Yet another tension the therapist must balance is that of the alliance with the family as a whole. The family relationships may be complicated by issues posed by marital tensions, the family's style of interaction, or poor communication. Only after each of these assessments is completed can the therapist begin to define with the family the various ways that they can choose to begin to resolve their concerns.

At first, the treatment plan may only address the needs (or diagnoses or both) within one element of the system (child or adolescent, parent, or family). The focus will be on success. The classification of the zone of care, introduced in chapter 2 and expanded in chapter 4, will help the therapist identify where best to begin. When the clinician can classify the nature and level of difficulty in the function of the child, parents, family, or all of these, the family and therapist can more quickly direct his or her energies to the relevant problem area. The child and family's function, taken together, will fall into one of four zones of care.

Zone 1 is the zone of normal developmental progress. Here the parenting skills and constitution of the child are "good enough." Here a range of outpatient short-term, family-based approaches to child or family problems is often quickly successful. These are the children and families whose care has been "carved out" by managed care organizations (MCOs). These are people who have insurance

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through employment and most often have relationship skills as well as the many ego strengths and positive coping styles needed to work quickly in treatment.

Zone 2 is the zone of child despair. Here the child's family context is that of a severely dysfunctional family or adult impairment leading to parental failure. Here the treatment must direct itself to the search for resources that can support the child's health and resilience. Referrals for treatment of the parents are usually not implemented by them. Family contacts, or reports elicited from the child, may only lead to filing with a state agency for child welfare. A classic individually based therapeutic approach may not be possible in typical outpatient settings. Longer term therapies may be developed for these children in their school placements to help them deal with the intense affects of loss, trauma, and anger. This type of treatment, however, risks heightened loyalty conflicts for the child and, as a result, is often resisted by the child or is not consented to by the parent. In some cases, however, the treatment relationship may remind a child of the hope that there can be adult relationships that can be trusted where nonfamily-based issues can be addressed and solved.

Zone 3 is the zone of parental grief. In this instance, the child is affected by severe developmental, medical, or psychiatric disorder. Treatment of the "good enough" parents should help them mourn the loss of the healthy, normal child and help them search for ways to enhance the adaptive capacities of their child. Child-based therapies will be appropriate, depending upon the diagnosis and nature of the child's developmental compromises, at different stages of the long-term relationship with child and family.

In the classic *zone 2 to 3* switch, i.e., where a child is removed from a dysfunctional home and placed in one in which the parenting skills are "good enough," child treatment is often needed to address the past trauma. In the context of secure supports—with the simultaneous loss of the parent(s)—the child may become extremely symptomatic. The treatment can focus on these issues while helping the child consolidate the newly available relationships. The adoptive parents may need guidance and support in parenting meetings, while the "new family" relationships are supported in a family-based treatment.

Zone 4 is the "most at risk" zone. It consists of those children with seriously compromised function and their families who are most dysfunctional. The parental or familial dysfunction may lead to involvement of other agencies, but the child is not removed. Here the therapist is most at risk of feeling a sense of helplessness and hopelessness. This feeling represents the countertransferential mirror of both the parent, who feels helpless in the face of the child's behavior, and the child who feels hopeless about the help the parent may offer. Treatment must be directed toward mobilizing ancillary systems involvement (schools, child welfare agencies, and other outreach programs).

The model of the zone of care and the diagnostic formulation together will help the therapist prioritize the initial goals of treatment within the fiscal contract. The family must consider how to make these decisions with the therapist about implementing a treatment plan that lies within their financial resources (available insurance, self-pay, or other components). Since mental health benefits are so often limited, the therapist may need to help the family access sources of support that rely on other sources of funding: community activities that exist

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for children, school supports or agencies that help children access tutors, after-school programs, or summer camps.

Following the assessment, the therapist's skills will help the child and family identify which goals the family might most successfully tackle together with the therapist. This text will suggest how the initial diagnostic "homework" and the first treatment suggestions can be oriented to success and help prioritize the next objectives. The result of this first phase of the therapy should lay the foundation for any longer term goals, which may be reached through more continuous or more intermittent contact. The realities of most mental health plans often mean that the short-term plan may be all the family can afford if they must work within their insurance benefit.

Like much of the current literature and reviews of child and adolescent treatment, *Sharing Care* is oriented to the use of multimodal treatments for a wide variety of child/family difficulties. The ways to intervene with children and families often includes, even in a short-term intervention, a creative combination of individual play and dynamically oriented verbal therapies, parenting education and guidance, family therapy, cognitive–behavioral strategies, and psychopharmacological interventions. The authors will continue to emphasize that these are best contained within a family-based approach.

This treatment model asks the therapist to promote the child and parents' teamwork in problem solving while the therapy enhances the fundamental strengths of their relationship to one another. The therapist's knowledge of a wide variety of interventions can help the family members decide how to invest their energies and resources to support the best possible outcome for themselves. The reader will be referred to many of the key readings in child- and family-based assessments and treatments that complement the approaches defined here.

Planning Short-Term, Intermittent, and Long-Term Therapies for Children and Families

The short-term aspect of the treatment plan should first be oriented toward trying to enhance the family's relationships, increase understanding of the problem to further active mastery (coping), and to ameliorate any presenting symptoms. Any success will lead to a continuing process of growth and development that permits new choices, an expanded emotional, behavioral, and cognitive repertoire, and the child and family's improved sense of relationship and exchange. Unfortunately, for some, the course of treatment may see the evolution of a more complex psychiatric disorder in a child, or more complex parenting problems or family dilemmas may become apparent.

When the child's or the family's development is challenged by forces and difficulties that do not readily yield to treatment, the role of resources, whether insurance or the family's ability to pay, will have a greater impact on what treatment may be possible. The effects of parenting difficulties, the severity of the child's disorder, any underlying psychopathology in the parents, or high levels of family conflict may demand more treatment meetings than are available. For some children, the type of resources that are needed are not those that standard

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outpatient mental health treatments can provide, such as a structured school program, a midnight basketball program, or parental and community solidarity about standards of drug or alcohol use. For other families, their difficulties may involve the lack of resources, which doesn't allow them to provide basic care for their child. These interventions require community support that is dependent upon the values and votes and dollars of a society.

☐ Working with Families to Manage the Use of their Resources, Insurance, and MCOs

The intervention must take into account the complexities of the presenting problem, the players in the family, *and* the surrounding fiscal conditions (increasingly presented in the form of an MCO). Mental health funding is an enormous issue for American society. The existence of, as well as the treatment for, mental health and substance abuse disorders continues to be debated in political circles. From a clinical perspective, therapists face, with clients, the enormous pain and turmoil that mental and relational difficulties create. For those who work with children this is an even greater source of anguish since children are often at the proverbial bottom of the barrel in terms of resources (in spite of society's rhetoric).

This is amply demonstrated in the field of mental health for children. At the outset of a child and family assessment, the number of meetings needed to complete an initial diagnostic evaluation can be an issue. Even though each system within the family must be considered, clinicians are often given one meeting to complete an assessment. The extra time needed for child and family evaluation must be advocated for so that the treatment plan rests on a thorough understanding of child, parent, and family. Without this thoroughness, the treatment path is harder to find. Since the financial circumstances of most parents are limited, it means that therapists must consider and plan how to guide the family's choices about the use of their resources and how to advocate for themselves.

Treatment plans have always cost money. Therapists must deal with their own income. This income is based on a session and service rate that clinicians have established but that contracting insurers pay. These rates have declined as MCOs have developed contracts with providers even while burdening them with many additional, unreimbursed, administrative demands and treatment constraints. It is important to note that social workers' salaries have rarely been competitive with other master's level incomes. This is also true for Ph.D. psychologists and for the medically based psychotherapeutic providers, the psychiatrists, whose income is among the lowest of all doctors.

As therapists attempt to juggle the demands and costs of the treatment plan, as well as the relationship with the child and the family, the fiscal issues make keeping the therapist (and the working alliance) in balance a challenge. Therapists must be skilled and highly trained. Today's therapists are confronted with the "business" of mental health in even more stringent ways than other medical providers are. As a result, even with the wealthiest clients, therapists need to address fiscal issues. The task of managing money as part of a treatment plan is unavoidable. Even if Congress were to enact managed savings accounts as a way for families to deal with their own health care expenses, this same issue of the cost, as

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reflected in the number of sessions weighed against the family's perception of the benefit, would return to the family's decision making. The parents would then need to determine what they might spend on any psychotherapeutic intervention for their child (or themselves) from the first moment of care, rather than after some third party assistance.

Therapists have had a long tradition of managing financial choices in the therapy because mental health has been underfunded for so long. As a result, a child and family practice must orient itself to clarify and define the issues and the elements of the therapy *to parents*. There is no other way that a therapist can help parents become active in working with their resources or benefits. This can occur in the most direct possible way in the family-based approach defined here. In this context, the need for further sessions and their cost, or the forms of MCOs, can be used to help discuss the issues of care, the MCO's requirements, and the parents' choices that can be integrated into the clinical work.

As therapists struggle with these considerations, the countertransferential hate (Winnicott, 1958) aroused in some very demanding cases can make walking the tightrope of contemporary practice difficult. On the one hand, the influence and orientation of the MCO will have its weight on the fiscal tightrope openly acknowledged and so is an easy target for this feeling. On the other hand, the countertransferential hate can be directed toward the parent, since parents may elect not to accept treatment for themselves, may not address complicating family factors, and may resist additional expenses or needed care for the child, whether in the form of treatment, sports, or tutoring. They may fail to negotiate honestly with the therapist about money, or, in the final act, to pay off a balance.

This text is not designed to define or address the multiple concerns that exist in the financing of mental health treatments. Clinicians, as well as parents, need to be advocates for children in the national health care debate whose components are being written and rewritten. While much of a patient's pain and shame is not the focus of concern of these companies,[1] the ethical dilemmas therapists face about the privacy of the consulting room, how clients are helped to understand what information must be shared, their resulting decisions, or the way in which therapists have chosen to act, politically or professionally, is the subject of many other articles and volumes. However, fiscal concerns in treatment planning must be handled. As a result, the text will raise these issues throughout the case discussions, even while it is unable to finally solve them. There are times when needed treatment cannot be afforded and the therapist and family must share this pain together while they make "the best possible use of limited resources."

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[1]Simultaneously, another element of concern for therapists is the continuously opening window allowing greater informational flow to insurers about their patients' lives.

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PART

I

GETTING STARTED: AN OVERVIEW

Child[2] treatment is treatment of the family. First, the therapist must establish a respectful relationship with each member of the family and the child and family together. The therapist must be attuned to the child's individual needs while sensitively gauging the collective needs of the family and parents. Second, therapists who work with children and adolescents have to expect that parents also need to be treated as the therapist's patients: they too need to be understood. Empathy must be extended to their feelings as they face a dilemma with their child. The parents' psychological makeup must be assessed so that the therapist understands any contributing historical factors or symptomatic clusters in the parents that can impact on the recovery of child and family, or have contributed to the creation of the problem.

These primary relationships between therapist, parent, child, and family are established during the assessment phase. The therapist uses the initial contact to enhance the essential relational triad of treatment in work with the child, parents, and families (see Figure I.1). It is the connection between parent, child, and family through which the therapist must work. The family is the stage upon which the child readies his or her performance for life and the couple's relationship constructs the set (Lewis, 1998). These interwoven relationships become the platform upon which any future treatment plan must rest.

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[2]The text will use the term "child" to represent a condensation of the term "child or adolescent" as a matter of convenience.

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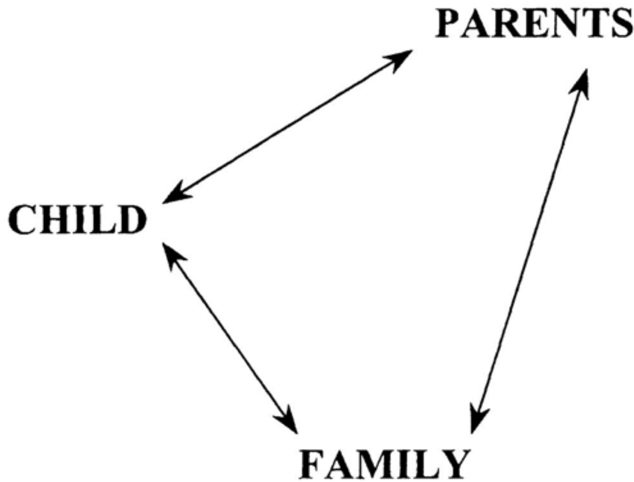

FIGURE I.1.

Any contact between the members of the family and the therapist should function to strengthen this triad of relationships. Each subset of the evaluation must be presented and conducted in a way that furthers the family members' care for one another. The therapeutic alliance is dedicated to reinforcing or strengthening the family members' sense of their positive connections with one another.

Whatever the origins of the dilemma the family faces, the implementation of the solutions should feel like moving toward a family victory. Treatment contributes to the further development of healthy parent–child–family relationships by increasing understanding, empathy, and communication. Where family relationships are strained, treatment may need, as a first step, to reestablish the bonds that have been stretched to breaking by a child or parents' symptomatology, developmental challenges, or environmental stresses. The parents must be able to understand and support the goals of the treatment or, at the very least, not undermine it.

Often, the more resources a family has, as well as its familiarity with the world of "professional advice," the more prepared it is to establish a trusting and active relationship with the therapist promptly, as illustrated in chapter 1. In the more challenging cases, an extended assessment phase may be required to lay a foundation for healing relationships before other work begins. As Dr. Herman says in *Trauma and Recovery*, "The belief in a meaningful world is formed in relation to others and begins in earliest life. Basic trust, acquired in the primary intimate relationship, is the foundation of faith" (p. 54). Even before the family can accept treatment, they must have faith to accept a therapist.

The child and family who have been disrupted by trauma need to find a way through the family's denial or blame in order to enter a treatment alliance. In chapter 2, a disadvantaged family is portrayed who may see the professional world through a lens of being blamed or shamed, and they mirror this process in their interactions with one another and the therapist. They defend themselves against any contact with the therapist. Their present interactions often perpetuate ongoing psychological trauma.

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Limited resources and continuing family conflict both diminish a sense of hope and a sense of trust in caretakers or future success. These families often see professionals as adversaries. As illustrated in this case, the establishment of a working alliance involves a process that makes the assessment very time consuming. Contact may not be possible within the constraints of a common office practice. If the family engages in treatment, sensitivity, combined with "plain talk," will be needed from the therapist. Establishing "a safe place," in Dr. Havens' terms, is no easy task (1989). Too frequently, an impasse develops that requires the therapist to actively diffuse the critical or negative stance these families may project.

The therapist must establish a style of communication with the family that promotes trust. The child and family should feel respected in the process of coming to terms with their strengths and weaknesses as they face the problem or search for a solution. The family's efforts to problem solve must be positively framed. The therapist should convey that the only purpose of his or her psychological and developmental knowledge is to enhance the family's success, not to pass judgment. The assessment should confirm to the family that it has taken a healthy step to acknowledge a difficulty and solve it by entering the therapist's office.

Because of the varying levels of dysfunction that may exist within the child or family or both, therapists must have a way to classify the nature of the challenges before them. Chapter 2 will describe four *zones of care.* These zones will prompt therapists to examine both the level of distress and the dysfunction that may be presented by the child or the family or both. The parental assessment (chapter 3) is an essential step in determining the strength or vulnerability that exists within the family. Defining the zone of care will direct the therapist toward the initial therapeutic tactics that may be required as well as what resources that may need to be mobilized from other community systems (chapter 4).

In order to make these classifications, a child and family therapist's perceptions must be informed by a broad knowledge base and understanding. The work requires a background in *DSM-IV* diagnosis, psychodynamics, affect and defense, character structure, and character disorder for parent evaluations. The therapist must use his or her clinical training both to establish a working relationship with each member of the family and to assess the member's function. However, to understand each family member is not to understand the family as a whole.

The therapist must gain skills at working with family systems so the therapist is comfortable sitting together with the entire family and "seeing them in relation to each other" in preparation for charting the therapeutic course. In some cases, a child's symptoms have resulted from stress or conflict among family members or between the parents. The assessment may clarify the pathway through which the child has become symptomatic, so the family members can be asked to focus their efforts on change.

Besides understanding adult and family assessment and treatment, a child and family therapist is required to understand child development. The skill of playing with children is an essential component of communication with them and of being able to understand and translate the child's concerns. The therapist must tell the child that the therapist's "ideas," drawn from the exchanges with the child, will be reviewed with the parents separately or in family meetings, so that the child and family can work better together. The therapist must help the child understand that the alliance is

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with the entire family. The therapist must have the skill to talk "straight" with children that is respectful yet appreciates the dilemma posed by both their current behavior and their past history (Cotton, 1993; Glasser, 1965). This includes discussing in a forthright way the parents and family's involvement and the therapist's responsibility to use judgment about the disclosure of child or adolescent behaviors that involve risk.

Finally, the assessment phase concludes with the therapist actively considering where and how the family's initial focus of attention for treatment will be directed. As the therapist considers all the possible avenues through which a "child-focused" problem can develop, the assessment should have helped to specify the most germane determinants, whether they represent developmental disorder, psychological conflict, *DSM-IV* disorder, family pathology, a parenting problem, or a cluster of all of these. Whatever the origin (and it is often possible that one can feel some uncertainty here) a treatment direction that balances an element of each of the following triad of goals can be defined.

As proposed here, treatment requires the therapist to pursue a triad of goals (see Figure I.2) that is built upon the platform of the family's relationships. This triad of goals directs the family to understand (implicitly or explicitly) how the treatment will

1. support and further the development of healthy relationships,
2. promote active mastery (coping skills) of the emotional or situational challenges the child and family confronts, and
3. find methods that help to reduce symptoms.

It is no accident that two of the triad of goals defined here are those that Dr. Herman reviews in her discussion of resilience in the face of trauma. "Stress resistant individuals appear to be those with high sociability [relationship], a thoughtful and active coping style [active mastery], and a strong ability to control their destiny" (p. 58). This last factor, described elsewhere in the psychological literature as an "internal locus of con-

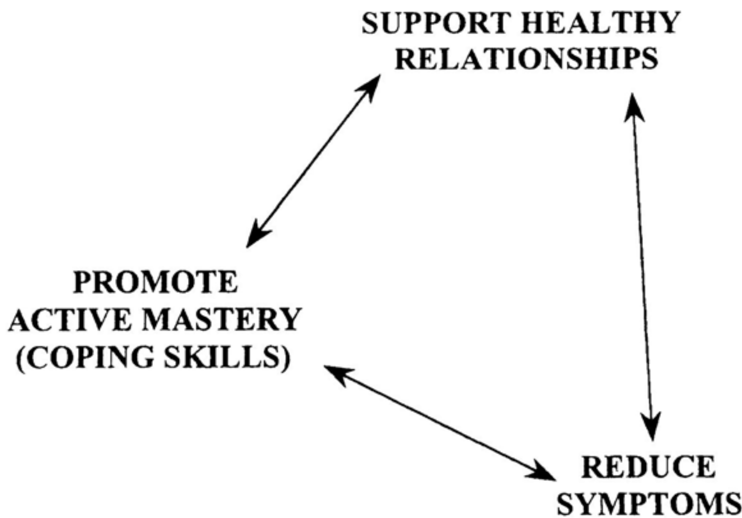

FIGURE I.2.

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trol," is included here as the part of the treatment goal called active mastery/coping. Since both relationships and coping are undermined by the presence of active symptoms, the therapist must focus on symptom reduction as the third essential goal.

The therapist's own personality, way of working, and the variety of skills that a therapist will continue to develop will be drawn into this triad of goals in a flexible, everchanging way. The therapist's moves will be determined by the therapist's consideration of which focus may yield the greatest benefit. Several directions may be tested simultaneously. The goals, however, remain the same: to support good relationships, active mastery (coping), and to promote health (symptom reduction). Each move toward one goal can support the efforts to move toward the others.

Supporting Healthy Relationships. While the treatment will rely upon a working alliance between the family and the therapist, the family members' longer term success will depend upon their ability to continue in healthy relationships with one another. Optimally, all treatment efforts should promote healthy contact and problem solving between parent and child and in the family so that this outcome is supported. We will describe parameters the therapist can use to assess the various dimensions of the relationships within the family and between parent and child.

Active Mastery (Enhancing Coping Styles). The contact with the child and family should permit the therapist to understand how the parent and child cope. Broadly defined (Kottmeier-Leandro, 1995), the two major ways of coping are (1) by managing feelings and (2) by taking action. Women more often use coping techniques that manage feelings, whereas men are more likely to take action. Each coping style is more likely to work in different situations. Managing feelings is essential when no action-based solution is available, for instance, following the loss of a loved one or in increasing intimacy in relationships. Action-based coping techniques work better when there is the possibility to influence the outcome of a problem through "doing something." Being able to utilize both coping styles appropriately is optimal. Understanding the child and family's coping style can guide how the therapist promotes mastery of feelings and the active implementation of solutions.

Symptom Reduction. The reason symptom reduction is placed on an equal level with mastery and relationship is that many of the problems that therapists treat involve the presence of symptoms that can actively interfere with coping (e.g., depression) or relationship (e.g., irritability) or mastery (e.g., anxiety). Continuing assessment must identify and minimize any active symptom profile in the course of the therapy.

Assessing the degree to which coping styles are compromised, relationships are dysfunctional, or symptom levels are high, will, in turn, contribute to the therapist's assessment of the nature of the zone of the problem. Each aspect of the assessment helps the therapist gauge which factors may bear more weight in the definition of the zone of care. Establishing a zone of care can provide an initial direction for treatment as based in the broad outlines suggested in chapters 4, 5, and 6.

Note that most clinicians feel their clinical formulation guides their treatment planning. But, as Smith and Beck (1998) ask, "What do we make of the fact that clinicians with markedly different views all believe they make 'good' case formulations that will

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work for the clients they serve?"[3] We propose that however a clinician formulates a case, the successful treatment has, in some way, combined elements of restoring relationships, creating active mastery, and reducing symptoms.

Whatever the origin of the problem before the therapist, its persistence is often traumatizing for the child and family. An element of demoralization has set in. Part of the early "placebo" effect in treatment occurs when families again attempt active mastery by engaging with professional help. The therapist should attempt to heighten the child and family's optimism in the initial contact. The therapist can assess the level of the family's readiness to take action by the assignment of homework tasks. Further light will be shed on the ways that both parents and child begin to cope by reviewing their efforts to complete the homework task.

The family's faith in therapy as a way to find solutions will depend upon the therapist's ability to respect all members of the family and to establish hope for a positive outcome. It is important that the family be able to sort out that the therapist's work will not mean agreeing with each of the members all the time. While scorecards are often kept, when the therapist is dedicated to solutions that ultimately make everyone in the family feel better, the family will accept the therapist's shifting perspectives.

Even if *everyone* (parents, child, and other family members) must work a little harder to handle a problem, the therapist sets the stage for the family's success. It is not the particular details of each "therapeutic move" that will determine the outcome of each case. Rather, it is the therapist's respectful and persistent search for the strengths and special connections between the child and family that is what the family will hold in their minds in the long run. This value is what the family will use to find whatever victory there may be for them.

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[3]According to Smith and Beck, "Most clinicians believe it is important to have a good case formulation to guide therapy. While comforting to believe, it is a proposition difficult to defend. What makes a case formulation good (truth, beauty, utility)? What do we make of the fact that clinicians with markedly different views all believe they make 'good' case formulations that work for the patient. Tension between the fragility of our clinical knowledge and importance (or use?) of formulation in directing treatment" must be acknowledged.

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CHAPTER

The Initial Contact: Introductory Concepts

Getting started: "The Perfect Case: Jessica"

The Initial Phone Contact: Setting the Stage

Mrs. Gardner has called and left a message asking if the therapist can call her to discuss some concerns she has about Jessica, her 9-year-old daughter. The therapist returns the call.

The therapist welcomes Mrs. Gardner. The therapist asks how she got the therapist's name and how she thought the therapist might be of help.

What the Therapist Is Attempting to Accomplish

1. Therapists should establish a sense of their referral sources for two reasons. The first is that it will help identify how the therapist is known in the community. A key part of building a practice includes the development of relationships with referral sources (whether the family ultimately gets to see the therapist or not). The second is that one comes to know the expectations and needs of different professionals in the community who refer.
2. A therapist offers a professional service. It has two key components: (1) a body of knowledge on child and family development that can be accessed to establish a working assessment of the problem and the skills used to treat the problem and (2) the relationship skills that permit a therapist to establish a "working alliance," i.e., one in which the therapist develops a partnership in which the parents' involvement will be key to the outcomes.

   Throughout the course of the diagnostic phase (described in Part I) and the treatment phase (Part II), the therapist will be constantly interweaving these two skills in the interaction with the child and family.

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Mrs. Gardner says that Jessica has begun to pull tufts of stuffing out of her mattress at night, cannot get to sleep, and is complaining about all the other children in her class not liking her, in spite of her having several best friends.

Mrs. Gardner describes her family briefly. She is a computer programmer and her husband is a teacher. They have recently adopted a baby from China and her mother ("Nana") has moved into their home to help with the transition. She describes how Jessica was involved with all of the planning and was quite eager to have a new baby in the family.

The therapist's reactions:

- A treatable problem has been identified in a cogent way; the parent appears sensitive and attuned to the child.
- The therapist wonders about the parent's description of having Jessica "involved in the planning" and whether that represented a burden for the child or was done in a developmentally appropriate way. This question is noted for consideration within the context of the diagnostic phase since the therapist's pocketbook will not be well served by spending a large amount of time on the phone.

Even though the therapist is hearing a key description of the concern, the therapist must still reserve judgment about whether the "problem" is "*the* problem" or whether in the context of both family system evaluation and child diagnostic review the focus of treatment may be different.

At this point, the therapist cannot draw a conclusion; however, it is time to affirm what the therapeutic transaction includes:

(1) *Therapists offer knowledge.*
  - The therapist can validate mother's concerns as reasonable and suggest that an assessment is indicated.
  - Part of the assessment, the therapist explains, is to require that the parents fill out a variety of forms and checklists to make sure the therapist has the full range of information that will help her consider various issues in the assessment. The therapist can ask if they would like these to be mailed or if they would like to come to the therapist's office a bit early to do this work in the waiting room.

(2) *Therapists offer care in the context of the therapeutic relationship.*
  - The therapist explains to the parent that she appreciates the parent has taken action on her daughter's behalf and that it sounds as if it is genuinely difficult for Jessica, as well as the whole family, at this time of change.
  - The therapist lets the mother know that she can explain to Jessica that she will be coming to see a "helper" who knows about kids and about the many different ways to help them and their families when kids feel worried or unhappy. The mother should be told to let Jessica know that the therapist will meet with the family, with Jessica alone, with her parents alone, and then give them some ideas about making things better.

The third point in an intake call has to do with business.

(3) *Therapists offer a service within a contractual relationship.* Since this is a professional relationship, the therapist must introduce and explain fees and that the therapist works with many different insurers. Since there are so many different insurance programs (and mental health benefits are often more complex than medical ben-

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efits), the therapist should explain that the parents should gather information about their mental health benefit, any authorizations needed, or other steps they may need to take. The therapist should explain to the mother that she and her husband can best access this information from their plan, since benefits vary widely depending upon their employer and the nature of the contract they may have. The therapist will also explain that the last few minutes of the initial meeting will be saved in order to allow the parents to report what they have discovered about their insurance coverage and how to create a plan together that takes into account their insurance benefit and their own resources.

Mrs. Gardner thanks the therapist for the information. She says she will speak with her husband about their benefit and will get the paperwork in order before they visit so that any insurance information or authorizations are obtained. She agrees to an initial visit in which all three of them, she, her husband, and Jessica, will attend. She reports that she feels relieved about what to tell their child.

By the end of this conversation, the therapist has set the stage for the parents becoming active partners in the assessment by asking them to participate in joining the initial visit with their daughter and then by filling out a variety of checklists and history forms. The therapist has also set the stage for the parents to recognize that, in some fashion, the therapist will be working together with their insurer and discussing resources for treatment.

The therapist has already established that the structure of the first appointment of the assessment process will have three parts. There will be an introductory family-based meeting, a child meeting, and a brief parent contact to get insurance information and plan the rest of the assessment. Depending upon the nature of the strengths of the family and child, these three components may be accomplished in a single meeting or may require other separate meetings. In a single meeting, approximately one third of the time will be devoted to the family-based meeting; one half of the time will be spent with the child; and one sixth of the time will be spent in a brief review with the parents. The therapist will set the stage for the parent evaluation session (chapter 3) and the family-based treatment planning meeting (chapter 4) to follow.

As a result of the therapist's phone call with the Gardeners, the first impression suggests that it may be possible to complete these three elements in the first meeting. The parent has been able to describe the concern cogently, clearly appears to have a positive relationship with the child, and enters willingly into a diagnostic process with the therapist. The parent also appears to be willing and able to assume responsibility for the fiscal contract in the professional relationship. In the less than perfect case described in the second chapter, we will be looking at the elements that might prompt the therapist to think otherwise.

The First Appointment: The Family Component

When a child is asked to see the principal or when parents are invited to a parent–teacher conference, there is often a worry about judgment, disapproval, or both. The initial family contact with the therapist needs to dispel these notions. For the child it is designed to establish that the parents have a concern about him or her. In the course of the consultation the child's behavior or some feelings may be reviewed, but the therapist will want to help the child see that the parents care and want to help the

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child feel better and do his or her best. There is an openness to the communication that the therapist can encourage. In most "good enough"[4] functioning families, the child is already aware of this. Most parents will attempt to describe or resolve those troublesome moments of distress in their children's lives in some way, and it is unusual when these efforts have not preceded the therapist's meeting with the family. The therapeutic contact exists along the continuum of the family's access to their own problem solving, and the parents can be reminded of the value of their efforts in the course of the initial description of the presenting problem.

The three main objectives in the initial phase of the focused family-based meeting, which takes place before seeing the child alone, are the following:

(1) To define the presenting problem(s) in a neutral and caring way that blames neither the child nor the parents. This will be the focus of the therapist's overt interactions with the child and family. Most families enter therapeutic consultation with a point of view about the presenting problem. This needs to be respectfully reviewed.
(2) In addition, the therapist must also rule out or define the symptom complexes that may be present and affect the child's function. Without attending to this potentially complicating factor, the parents will not have the full benefit of a diagnostic consultation with a developmental expert. (See Tables 1.1, 1.2, and 1.3.)
(3) Another, although more covert, objective is to establish an initial assessment of the nature of the relationships within the family by observing the nature of how the child and parents relate to each other as they describe the presenting problem. The therapist will see how they discuss the symptoms they are concerned about and how they interact with each other and with the therapist.

> Mr. and Mrs. Gardner come to the therapist's office at the designated time with Jessica. They have in hand a sheaf of papers. The therapist welcomes them and receives the checklists and insurance forms. The therapist explains to Jessica that one set of papers is about things her mother and father have noticed and the others are "business papers" that the therapist will discuss with her mother and father later.
>
> The therapist tells Jessica that she spoke to her mother about a week ago. The therapist asks Jessica if she knows why her parents have brought her to the office.

This question is asked in order to define:

(a) Whether Jessica recognizes what the problem is at her developmental level.
(b) Jessica's response will offer a clue about the level and nature of the parent and child communication.
(c) The therapist will observe how the child manages a "novel situation" and what her emotional and coping resources are.

Note: The therapist has also just told Jessica that she "knows her Mom" and that gives the child permission to begin to talk.

> Jessica begins to cry. Her mother waits a minute and then gives her a tissue. Her father says, "It's okay. Remember we told the therapist that we wanted to see somebody who helps kids and families. It's all right to talk to her."

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[4]See D. W. Winnicott's (1965) article on "good enough" parenting for an important discussion of the parental contribution to child development.

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