PART I

CHILD MENTAL HEALTH FUNDAMENTALS IN FAMILY CONTEXT

The fundamentals of child mental health are assessment and treatment, and the basics of assessment are how children are functioning at the intersection of development and context. As this book promotes the treatment of young children in context, Part I presents the fundamentals of emphasizing both an understanding of context and of working with young children, people in the process of forming themselves.

Developments in the understanding of neurobiology and human genetics have tipped the nature versus nurture dichotomy in favor of nature. The chapters in Part I will balance the tension between nature and nurture. Children are individuals with unique biological, physiological, and temperamental compositions, but who live and grow in families.

The chapters in Part I are intended to expand the professional's consideration of context, family context in particular. Assessing children, and thinking about and understanding how context facilitates development and the expression of children's behavior, leads to unique formulations that include the family and the family's own context. These in turn lead to decisions about treatment that evolve from an understanding of each family's unique patterns, abilities, and needs.

Chapter 1, by White and Chasin, brings the family into the traditional playroom of child therapy, expanding play therapy to include the family. Part I begins with this chapter to illustrate how traditional modalities can readily accommodate the family.

In Chapter 2, Fox reviews basic lines of development in early childhood, emphasizing the interplay between the developmental thrust that

seems to be built into the "germ" of each human being and the context that facilitates movement to maturity.

Lawrence's presentation of an assessment tool for families in Chapter 3 provides an excellent review of formal ways to gather information about families. She offers dimensions of assessment that add to the usual evaluations of family membership and organization and assessment of family resources. Her proposed protocol, the FIRST, also recognizes the value of the family's participating in the assessment process. Every assessment process challenges those being assessed to think about themselves in light of the questions being asked. This chapter discusses how that process enhances the family members' appreciation of themselves and the work they may engage in during treatment.

Josephson (Chapter 4) takes on the current overvaluing of biology over context head-on, illustrating alternative ways to think about behaviors that may often have quickly led to a diagnosis of a "biological" disorder and the administration of psychotropic medication. There are biological disorders and there are behavioral disorders. Although both may be modified by the powerful agents available for focusing attention, "stabilizing" moods, and subduing runaway thoughts, as well as sedating children with impulsive and aggressive behaviors, children's responses to medication do not necessarily indicate that they have biologically based conditions, and even biologically based conditions do not necessarily require psychopharmacological interventions. He reminds us of the extraordinary importance, once again, of changing context, understanding children's sense of belonging, adjustment, education, and responding to expectations.

In Chapter 5, Kramer reminds us that context *is* biology. After providing fascinating ethological evidence of families as biological units, he issues a stern warning about the current disruptions in connectedness in families, not just by separating and moving, but also by engaging in individualized, compartmentalized activities, such as watching TV in separate rooms and playing video games or engaging in Internet exchanges for hours, in lieu of family activities such as dining together, talking to one another, rejoicing, and comforting.

CHAPTER 1

The Child in Family Therapy

Guidelines for Active Engagement across the Age Span

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Over the past 40 years, the field of family therapy has made great strides in developing well-articulated theories and a rich repertoire of interventions. Less impressive is its development of techniques and practical guidelines for conducting sessions with families—whole families, including young children. In fact, in actual practice, children are more frequently excluded than included in family therapy. This condition prevails even though some of the earliest family therapists had a special interest in children, and though over the years frequent reference has been made to the value of including latency-age and preschool children in family treatment (Armstrong & Simpson, 2002; Augenbaum & Tasem, 1966; Bloch, 1976; Botkin, 2000; Chasin & White, 2003; Dowling & Jones, 1978; Gil, 1994; Keith, 1986; Ruble, 1999; Zilbach, 1986). A clear advantage cited for including children is that it makes them available for the therapist to observe and involve directly. It is generally agreed—at least in principle—that the family is better understood when all family members are present. Moreover, those who include young children in sessions testify that each child brings to the session not only a separate viewpoint, but also uniquely evocative and contributory modes of communicating, often characterized by immediacy, spontaneity, and refreshing candor.

Children have been excluded from therapy sessions for many reasons. Sometimes they are left out to protect them from harmful information or actions (e.g., when the session is likely to focus on adult sexual relations or when the adults involved are in poor control of destructive impulses). Ackerman (1966) and Dowling Jones (1978) suggest some reasons for in-

cluding children, even in these situations. Furthermore, family therapists whose theoretical approach is working with adults and their families of origin do not include children (Bowen, 1978); these therapists do not usually work with families in which children are the identified patients.

Yet even many who espouse approaches that call for direct observation and intervention with members of all generations exclude children from most sessions in practice. Perhaps the most popular explanation they give is that the heart of the problem and the ultimate key to the solution lie in the parental subsystem; therefore, seeing the parents alone is the most efficient way to help the family members.

In many cases these explanations for not including children simply rationalize the therapists' fear that they may not be able to effectively engage adults and children in therapy simultaneously. These hesitations are based largely on lack of experience. Therapists who work primarily with adults may worry that young children will become bored and resort to distracting behavior to gain adult attention (Villeneuve, 1979). Child therapists may worry that their repertoire of play techniques will engage the children but not the adults. Moreover, some practitioners may be concerned that parents will feel intimidated by a therapist's expertise at understanding and relating to children. Or some child therapists may bring to their work with families a stereotype about parents (e.g., parents as destructive or as well-intended but inept at meeting their children's needs). Such a bias is likely to contribute to therapist anxiety and to parent alienation. Finally, some therapists are experienced and confident in working with children and with adults, but not in the same session. They may resist including both because the techniques they use with adults and with children have so little common ground.

Our aim in this chapter is to provide practical guidance to therapists interested in developing techniques within that common ground—techniques with which active engagement of all family members, regardless of developmental level, can be promoted. We begin with practical suggestions about physical space and equipment. Next, we discuss play techniques that have served us well in our family work with young children. Gil (1994) has many additional suggestions for appropriate activities for children and parents in family therapy. Finally, we present a model opening interview for families with young children. This model is intended not as a rigid procedure, but rather as a guiding support for therapists in their efforts to engage children and adults together in the therapeutic process.

SPACE

Most settings for family therapy are poorly designed for work with whole families. There are problems with size, furniture, and equipment. However, although we describe ideal conditions for seeing whole families with young

children, most offices can be adapted for such work without a major overhaul.

Therapists must apply their sensitivity about context to the physical layout and materials of their working space. Too often a therapist will assume an attitude of denial and passivity about these conditions and will neither comment on them to the family nor attempt to do anything about them. Even when little can be done about the physical circumstances, it will help to build an alliance with the family if the therapist points out the problems of the space and works with the family to minimize its hindrances.

Furnishings and play materials should accommodate both full family interaction and separate subgroup activities. An ideal physical space has four areas—one each for observation, time out, discussion, and play (see also Bloch, 1976; Chasin,1981; Zilbach, 1986). A complex of four such areas affords many options: full togetherness, distance without physical isolation, observation without interaction, and total physical separation. The discussion and play areas should be composed of one large space partially divided by a movable screen. This space should be sparsely furnished with simple objects, such as movable chairs and large pillows. But if therapists have more conventional offices, they can simply supply some pillows for children to sit on and a toy box or storage cabinet for basic toys. Some way to delineate space on an ad hoc basis may also be useful.

The flexibility of such furnishings allows the therapist to clearly shift focus from one subsystem to another; it also allows for a "stage" to be set for play enactments. The observation area should be big enough to accommodate professionals and family members simultaneously. Its one-way mirror should provide a good view of the discussion and play areas. Video equipment that can be controlled from either side of the mirror is extremely useful. A waiting room with an adjacent bathroom can serve as a time-out space. It should be cut off both visually and acoustically from all other areas, so that family members can temporarily withdraw from the interviewing activity.

The play area should be equipped with toys meeting the following criteria. First, they should be safe and nondistracting (i.e., not too fascinating). Toys should be excluded if they are dangerous to swallow, have sharp points or edges, or make loud, frightening noises. Second, the toys should lend themselves to play that children and grownups can all interpret. Generally, it is easier to make sense of what a child does with hand puppets representing family members than it is to decipher what he or she does with an open sack of marbles. Third, toys should lend themselves to active and creative play rather than obsessive, repetitive routines. Although any toy can be used spontaneously or obsessively, some toys, such as magnetic darts or even dollhouses, tend to draw children away into evasive rituals. In contrast, a bataka (a fat, soft, harmless bat) rarely engenders that risk. Fourth, toys should allow for interaction between children and adults. Baby dolls usually serve that purpose better than puzzles that are designed

for children to work with alone. If a child brings a favorite toy, the creative therapist can take advantage of this and incorporate the toy into at least some part of the play scenario.

More important than the reservoir of toys is the choice one makes about which are to be made available for the session and which are to be left out of sight. The therapist should select toys according to the developmental stages of the children and to the issues being addressed by the family. For example, if the parents have been unable to manage the anger and neediness of a 3-year-old following the birth of a new sibling, the therapist might provide a baby doll, a blanket, family puppets, and a bataka or two to serve as harmless weapons.

As the session moves along, more playthings can be offered—it is easier to offer more later than to remove toys from a vast and delightful handy array.

PLAY

Therapists who work with young children rely on the revealing and therapeutic nature of the child's most natural activity: play. Yet they clearly appreciate the fact that not all types of play are equally revealing and therapeutic for all purposes. In this section, we describe the types of play that we have found to be most illuminating and engaging in sessions with families with young children, and we emphasize those forms of play that tend to be underutilized.

For the purposes of this discussion, we classify play along three continua: distanced–involved, nondirected–directed, and imaginative–factual. Child therapists are typically trained to employ play techniques on the "left side" of the continua: distanced, nondirected, and imaginative. Although these techniques have great value and are not to be abandoned in family work, we argue that techniques representing the "right side" have been insufficiently used. Child therapy in the psychoanalytic tradition (Axline, 1969) tends to utilize drawing materials, clay, doll houses, and small rubber dolls in distanced play—play in which objects are often held at "arm's length," literally and sometimes experientially. Their manipulation by the child is interpreted by the therapist as revealing projection of intrapsychic and/or interpersonal issues. This interpretation then serves as the basis of intervention on the part of the therapist and the parents.

In the less used involved play, however, the child is the toy and the action usually requires little interpretation. The child may play a role in an enactment using no toys, or perhaps (in a slightly distanced form) using only hand puppets. Such play is particularly well suited for work with families, as it can be used by both children and adults, and it ordinarily communicates emotionally engaging information in an intelligible way. Yet, like

other forms of play, it provides a comfortable alternative to using words—a medium that is often ill suited for robust and clear communication across developmental levels.

Child therapists with a psychodynamic orientation typically employ nondirected play techniques. Such a therapist may offer the child materials (e.g., a crayon and paper) or may simply make available a stockpile of materials and tell the child to do whatever he or she pleases. Less frequently used directed play is clearly guided by the therapist. For example, a child may be asked to draw a particular picture (e.g., kinetic family drawing; Burns & Kaufman, 1972) or to enact a particular scene and play a particular role in it (e.g., "You're Dad at the dinner table and your brother is Mom, who has just arrived home late from work. Make up a skit that shows us what would happen if your parents got along exactly the way your mother wants them to."). Imaginative techniques generally involve the playing out of fantasies. Children may become kings or queens, monsters or animals; they may travel to nonexistent planets or brave wild, terrifying jungles. In contrast, factual play documents the actions and feelings of real people as they are now or could realistically be in the future (e.g., "Dad, be your daughter, and Mom, be the doctor. Show us what will happen at her checkup next week."). Factual play can be an easily comprehensible alternative to using words to explore real events.

The more traditional distanced, nondirected, and imaginative types of play are certainly valuable in many therapy contexts, including that of family therapy. Free drawing, as outlined by Zilbach (1986), is an example. The children work on their drawings while the adults are engaged in conversation, to which the nonparticipating children may be closely attuned. Through the drawings, the children may express their concerns about family relationships and "communicate family issues that might otherwise remain underground, or at least take much longer to be raised by adults" (Zilbach, 1986, p. 98). The drawings are interpreted both diagnostically and as clues to progress in family work.

However, there are many virtues to recommend the less traditional involved, directed, and factual types of play in the context of family therapy. To the extent that play is involved, families become actively engaged and display high levels of energy. To the extent that it is directed, it is efficient and to the point. To the extent that it is factual, it is directly informative about everyday life. Role playing usually exemplifies all three: it is always involved, it is usually directed, and it is often factual (although it can also be imaginative). Particularly notable among its virtues are the enthusiasm with which family members impersonate each other and the honesty with which they represent everyday life as it affects them. Of course, in these impersonations each family member may develop empathy for the person he or she plays and may gain fresh perspectives by observing his or her own behavior as it is played by those affected by it.

Many family therapists employ role playing in some form or another, and its virtues are well documented in the literature—in Haley (1976), Minuchin (1974), Neill and Kniskern (1982), Papp (1980), and Satir (1964), to cite a few examples. In fact, role playing has been used by representatives of most approaches in family work. Behavior therapists have used it to shape parental responses to child misconduct (Bernal, Williams, Miller, & Reagor, 1972; Forehand, 1977). Even though systemic therapists rely heavily on questioning to increase a family's awareness of its own patterns, role playing (in the form of ritual) is sometimes prescribed as a homework assignment. Some systemic therapists (e.g., Coppersmith, 1985) direct elaborate symbolic rituals within the session to expand the family's awareness of its patterns and beliefs and to trigger family change. Strategic therapists generally do not include role playing in their sessions. A luminous exception is Cloe Madanes (1984), who may engage the family in a vivid dramatic enactment with a clear strategic purpose in mind. Most family therapists have one or two role-playing devices in their repertoires; some never use role playing at all. We believe it can be employed usefully in a wide range of ways in virtually any approach to family therapy, especially in sessions in which children are included. The following vignette is an example of an involved, directed, factual role play:

In the initial contact with the parents, the therapist was told that the identified patient, Pat, age 9, was suicidal and was intensely jealous of and competitive with her younger sister, Sue, age 6. Pat told her recently separated parents that she would remain silent in an individual or family session. After an initial interview with the parents, which established an urgent need for accurate assessment, the therapist chose to see the girls together, assuming that Pat could not resist talking in the presence of Sue.

After joining with both girls, the therapist introduced the idea that puppets could play the roles of family members. The girls became involved with the puppets immediately. At first the tone of the play was humorous, with much joking about the puppets' messy hair. "I'm not looking my best today," Pat said on behalf of the puppet, giggling. Eventually, each girl had a chance to enact the mother's response to Pat's unhappiness. Then the therapist, playing Pat, asked:

THERAPIST: (*as Pat*) You know what I'm especially not happy about? Daddy's going away. Why did he go away?

SUE: (*as Mommy*) I don't know. You'll have to ask him.

Pat later played herself and spontaneously stated that Daddy went away because he fought with Mommy too much. The therapist suggested that the girls do a "Mommy and Daddy fight."

PAT: (*as Daddy, with a deep, pompous voice*) Did you see anything in the paper today about acid rain?

SUE: (*as Mommy*) Don't ask me that, I never look at the paper. You should know that by now!

PAT: (*as Daddy*) Well, you'd better start looking.

SUE: (*as Mommy, angrily*) Don't tell me what to look at.

PAT: (*as Daddy*) You're my wife.

SUE: (*as Mommy*) You shouldn't tell me what to do even though I am your wife. We're not related except by marriage. (*The parent puppets hit each other throughout the scene.*)

THERAPIST: That was very good. Want to do another one?

At this point Pat decided to be Mommy. Sue stated that Mommy should start the fight this time.

PAT: (*as Mommy*) What were you doing last night?

SUE: (*as Daddy, in a deep, long-suffering voice*) Working at the office.

PAT: (*as Mommy, in a sarcastic tone*) With Carla?

SUE: (*as Daddy*) No, I was working with Bill.

PAT: (*as Mommy*) He doesn't work there any more.

SUE: (*as Daddy, obviously evasive*) I mean I was working with what's-his-name.

PAT: (*as Mommy*) I'm going to get my hair done tomorrow. I expect you to stay with the girls.

SUE: (*as Daddy, importantly*) No. I've got an appointment.

PAT: (*as Mommy*) I'm going right now. Goodbye.

SUE: (*as Daddy*) Pat, I want you to take care of Sue. I have to go to a conference.

PAT: (*as herself, with original little girl puppet, speaking in a high-pitched, panicky voice*) No, you have to stay here.

SUE: (*as Daddy*) Well, get Sue. We'll all go to the conference.

PAT: (*as herself*) No.

SUE: (*as Daddy*) Well, I'll have to put you in bed. (*The father puppet angrily stuffs the girl puppets in a box.*) Get in your bed. (*Starts to leave.*)

PAT: (*as Mommy, just coming home, accusingly*) What are you doing?

SUE: (*as Daddy, defensively*) Ah, just going to check on something outside. Now that you're here, mind if I go to the conference?

PAT: (*as Mommy*) I do mind! I just came back for my purse.

The girls were highly attuned to the parental battle. Their mutual awareness that they had been abandoned by their angry, self-involved parents was now obvious. Pat's distress about having to care for her younger sister when she was not getting sufficient nurturing herself was also apparent. This role play was highly informative to the therapist and to the parents, who saw a videotape of

it. It also served to unite the sisters through helping each become aware that the other knew what was going on in the family; neither was alone with her distress. The bonds between them were strengthened by this method of revealing their shared misery.

Of course, role playing need not always be factual to be of value in family therapy. We offer here an example of an intervention (informed both by psychodynamic and structural theory) that used wildly imaginative play:

Bobby, age 4, was the identified patient. Much to the disgust of his older brothers, he was encopretic. His language was immature and he spoke in a high-pitched register. An initial evaluation session had taken place with his parents, but for this second session, intended to be an intervention, only he and his brothers, Josh, 9, and Paul, 13, were included. The three boys were quite distanced from one another; they were hardly a team. Age differences were exaggerated. The youngest seemed immature, and the eldest acted as though he were further along in adolescence than he was. The older boys stated that they wished for Bobby to communicate better so they could play with him, so he could be a "member of their club." The therapist asked them if Bobby got more attention when he acted like a baby. Bobby exclaimed defensively, "I am not a baby," and said that he wanted to be 6 feet tall. The therapist stood him on a high stool, and Paul cooperatively measured himself against Bobby, demonstrating that Bobby was now taller.

The therapist, squatting beside Bobby, suggested that Bobby act as though he were the oldest brother who could tell the others what to do because they were smaller. He coached the other boys to do as Bobby ordered. Bobby, enjoying this new experience, ordered his brothers: "Poop in your pants!" They pretended to do so. Bobby went on, "Now poop in the toilet!" Both older boys made believe they were following Bobby's directions. Liberated from their fear of childishness, they laughed hysterically and then began to hit each other with batakas, but stopped obediently when Bobby yelled, "Hold it! Hold it!"

Through this enactment, enjoyable to all three boys, the brothers' status had been somewhat equalized. The therapist now suggested playing a game called "Poops." Each boy was asked to hold an object (a pillow or bataka) symbolizing a "poop," and jump into the sewer and find out what happens to poops as they swim through the drainage. With the intention of further demystifying the toileting process for Bobby and unifying a disengaged sibling subsystem, the therapist remarked, "I bet you didn't know your poops had this much fun together. I'm gonna interview each of these poops. What happened to you?" The boys offered wonderful stories about the years they'd spent in the sewer, and the therapist exclaimed, "Look at all these other poops, brother poops. A whole family of poops." Bobby then excused himself, saying, "I have to go pee."

These are but two examples of the diverse uses of role play in family work with children.

BEGINNING FAMILY WORK WITH YOUNG CHILDREN

In their attempts to incorporate adults and children into the therapeutic process, many therapists may feel anxious: The sheer number of clients in the room places greater demands on them, not to mention the range of developmental abilities and concerns to which they must attend. Our purpose in outlining the structure of a model opening interview is to alleviate some of that anxiety—to provide a simple map for a therapist's journey. Undoubtedly, when therapists become highly familiar with the terrain, they will map out their own routes in accordance with their own styles and theoretical persuasions.

Preliminary Contact with Parents

If at all possible, the initial phone call should involve both parents. Together, they can best provide information on which to base decisions about the first session. Most important, no matter who is the index patient, the therapist will need to decide during that phone call whether to begin by seeing the parents alone, the whole family, or some other individual or subgroup.

More often than not, we begin with the parents (or other responsible adults) in order to establish the terms of treatment and have the appropriate permissions and releases signed. If symptoms are mild and acute, a single session with parents may be used to empower them, through support and advice, to experiment successfully with fresh approaches to the problem. If so, the child will not be seen and thus will be spared the feeling that he or she caused the family to seek outside help. If symptoms are severe or long-standing, a preliminary meeting with parents can be used to take a careful and extended history of the family and its past attempts to solve the problem. This information is most efficiently gathered without young children present.

A preliminary meeting with parents also provides an opportunity for the therapist to assess the parents, particularly with respect to their commitment to the work that may lie ahead, and gives the parents an opportunity to ask questions and express concerns about the expected course of assessment and treatment.

There are many important exceptions to the parents-first rule. We see the whole family first if the initial phone contact or referral has indicated (1) that it is the family's wish to be seen first as a family; (2) that adequate background information has been, or can be, transmitted over the phone,

obviating the need for an initial parent interview; and/or (3) that the parents feel secure enough to present the family directly to us. We may see a child first if the child so requests. Finally, we see a child or children without parents first in an emergency situation in which the parents are unavailable.[1]

The Family Interview

In presenting our model, we distinguish among six sequential phases: orientation, joining, goal statements, goal enactments, problem exploration, and advice to the family (Lee, 1986; Chasin, Roth, & Bograd, 1988). It may not prove possible to progress through all six phases in one session, especially in one 50-minute session. If two sessions are used, a natural breaking point between them is after goal statements and enactments and before problem exploration. We recommend scheduling opening interviews for 1½–2 hours. Even then, it may be difficult to complete all six phases in one meeting.

Orientation

The first part of the interview, the orientation phase, involves the therapist's sharing previously obtained information with the family and establishing rules and expectations. Because it is as important to engage young children in this phase as it is to engage older family members, the therapist must take care from the beginning to use language accessible to all participants. If at this stage (or any other stage) the parents or older children talk over the heads of the younger ones, the therapist can indicate that full engagement of the children is important by translating the remarks made by older family members into appropriate child language.

This can be done by simplifying phraseology and altering voice pitch and volume; brevity, repetition, and phrasing questions to require only simple answers (Snow, 1972) are all useful strategies. The therapist can also take cues from the parents, who usually understand quite well what type of language provokes responses from their children (Garnica, 1977; White, 1982). In general, we strive to make a habit of speaking in a family session in a manner that a 3-year-old with average language abilities can understand. We have included some examples of such language in our presentation of the model interview.

At the beginning of the interview, the therapist should introduce him- or herself and have family members introduce themselves by the names they prefer to be called. We suggest that parents offer their names first.[2] This will affirm their authority and establish an appropriate tone for children, who may get anxious and silly if asked to start.

Next, some background information should be offered by the therapist about prior contacts with the parents or others (e.g., school personnel), the

purpose of the meeting, and, in general, what may be expected in the session. Precise, carefully prepared information offered by the therapist at this juncture clarifies the nature of the meeting and makes it less threatening. Moreover, the therapist's openness can serve as a first intervention, modeling a standard of candor and clarity for the family.

In some cases, stating the purpose of the meeting will require reference to a child's "bad deed," but in those cases the therapist can demonstrate an interest in understanding all sides of the story. For example, a therapist may say to a child, "Your mother says that you have no friends, but she says that your father thinks you have friends and are kind to others practically all the time. So it might be important to talk about how to enjoy other children. It might also be important to find a way for your parents to agree." In describing their own goals, many therapists emphasize "learning more about the problem." We recommend a more forward-looking and corrective emphasis on "finding ways to make things better for everyone in the family."

We are dismayed that many therapists begin a first session by asking children, "Why do you think you are here?" This question often produces anxiety and defensiveness, because children may feel that they are blamed for whatever difficulties have brought the family into treatment. Such feelings should not be reinforced. Worse, the therapist may uncover that the parents have misled (or lied to) the children about the session. It is rarely a good idea to start a relationship by catching some one in a lie. If we begin by asking, "What have your parents told you about why the family has come to see me?" we are then all on the same page and can add more information as needed.

The second part of the orientation phase is particularly important in work with family members of many developmental levels. It involves the establishment of rules (Moustakas, 1959; Satir, 1964; Zilbach, Bergel, & Gass, 1972). In work with young children alone, the therapist, as the only adult in the room, is assumed to be keeper of the rules. In work with adults or older children, most rules are implicitly understood. When parents, a therapist (or two), and young children work together, ambiguity about "who's in charge" can sabotage the meeting by disabling the parents and provoking (ostensibly) disruptive behavior on the part of young children. Therefore, we strongly recommend that rules be clearly stated and that the authority for enforcing these rules be clearly delegated. Just as we counsel parents to provide clear limits in their daily parenting practice—secure boundaries within which their child's growth can proceed—we must also provide a similar space for growth through setting clear limits during therapy sessions.

There are three types of rules that must be established in every case. These are rules of discipline, safety, and noncoercion. Parents and children often assume that the therapist will take responsibility for discipline. We

recommend, however, that parents be asked to enforce the rules the family uses at home. Assigning the major responsibilities for discipline to parents emphasizes the boundary between the parental role and the therapeutic role, strengthens the parental position in the family hierarchy, and gives the therapist an opportunity to observe the way in which discipline is carried out in the family. The following example demonstrates the importance of clear delegation of authority.

A single mother, her 2½-year-old daughter, and her 6-month-old son arrived for their first family session at a pediatric clinic. Both children endured a few formal exchanges between the mother and the therapist. Then the baby began to scream and the little girl began to complain loudly ("I'm hungry," "I'm thirsty," "Let's go," etc.). She was offered a cup of water, which she spilled on the rug. She appeared to lose all control as she began to throw things around, and the mother did nothing to stop her.

A videotape of this part of the session was shown to a group of students, who were asked to comment on what they had observed. All expressed a deep concern for the mother's lack of intelligence, sensitivity, and executive control. When shown the next few minutes of the videotape, the students were humbled.

The mother, referring to the noise and chaos in the room, asked the therapist, "Do you want me to get this under control?" The therapist said, "Yes." The mother instructed the girl to get the baby's bottle from the diaper bag and then to either draw with crayons or build with blocks. The baby drained the bottle. The little girl played with blocks—a model of composure, creativity, orderliness, and active concentration.

The mother's handling of the situation, her tone, and her language were all that would be expected from an honors graduate of Parent Effectiveness Training. Contrary to the students' hypotheses, she exercised effective control with intelligence and sensitivity. New explanations of the previous chaos emerged: the mother was in a pediatric setting, in which parents are frequently encouraged to stand back passively and let the doctor—the expert—take over. No wonder she expected the expert on child behavior to be in charge! How much simpler it would have been had the therapist begun by explicitly giving the task of discipline to the mother.

Safety ought to be established as a joint responsibility; that is, it should be the duty of every individual present to intervene to protect the physical safety of every other individual. A noncoercion or "pass" rule gives each individual the right to decline to answer any question or follow any suggestion without giving a reason. This rule can be particularly comforting to children, who fear being "put on the spot," defenseless against intrusion by adults (Zilbach et al., 1972). Other rules will need to be made, depending on the circumstances of the case.

It may be important to establish with parents that no one is to be punished after the session for what is said or done in the session. In some cases, the therapist *must* make an agreement about confidentiality—for example, if he or she would like permission to discuss the case with school or court officials. In many cases, the therapist will suggest that family members agree not to share with others what happens in the session; family members can be offered an opportunity to review that commitment at the end of the session when they know what has transpired.

Finally, if the therapist wishes to tape the session, he or she *must* secure permission to make the tape and should offer the family an opportunity at the end of the session to discuss whether the tape is to be kept and for what purposes it may be used. If a session with a family subsystem is taped, the participants should be allowed to determine which other family members, if any, may be allowed to view it. One should exercise common sense in these decisions, of course, and not let a 2-year-old veto a sensible parental decision.

In our experience, the proper establishment of rules and expectations at the beginning of a session need not be time-consuming, nor need it inspire feelings of inhibition. On the contrary, it takes little time and seems to be a very wise investment toward a therapeutic process that is highly productive, liberating, and comfortable for all involved.

Joining

The purpose of the joining phase of the interview is to establish an alliance with the family as a whole, with the key subsystems, and with each individual.

When joining with children, it is important to avoid asking the sort of questions that children suffer through at gatherings of distant relatives: "How old are you? What is your favorite subject at school? You're in the first grade already—how nice!" Rather, the therapist should take clues from the child as to what the child is trying to express about him- or herself through clothing, jewelry, or hairstyle, for instance, and comment about these things. A well-worn pair of sneakers and a superhero T-shirt are likely to be more important expressions of individuality for an 8-year-old boy than his preference for spelling over math. In this case, one might ask the boy, "Are you good at sports? Are you strong?" Even better than a series of such comments and questions is an exercise that highlights the unique qualities or strengths of each family member. Such an activity will promote each individual's sense of feeling both esteemed and distinctive in the eyes of the therapist. Specifically, the therapist may say, "I'd like to hear from each of you something good about yourself—something you're good at doing or something you are proud of."

Ordinarily, it is wise to ask the parents to comment first. If they boast, it will make everyone less shy.

Stating Goals

Once rules have been agreed upon and rapport has been established through joining, the interview may take one of a number of directions. Some interviewers prefer to work in an organic, seamless way, without predesigned, well-demarcated, explicit steps. They may use something that has happened in the rule-setting or joining phase as a springboard to the next topic. We prefer to maintain clear expectations and state precisely what we are attempting to do in each phase of the interview. Although it probably does not much matter just how obviously the interviewer shifts gears, the choice of the next step is vital for the success of the evaluation. At this point, most clinicians ask the family to say what the problem is. Others give the family a general, exploratory, standardized task that is designed to reveal some aspect of family functioning or self-perception. For example, the family may be asked to do a kinetic family drawing to reveal how the family activity is perceived by all its members. Or the family may be asked to use blocks to show how the home is laid out. There are many such exercises available to therapists.

We believe that even after effective joining, many family members still feel quite unsafe. By focusing on the problem at that point, the therapist may foster a negative set in which people feel blamed, guilty, demoralized, and inept. Such a negative set, especially at this delicate juncture, endangers hopefulness and may undermine the family's exercise of its strength.

If a problem focus is too risky at this point, what is the difficulty with a general exploratory task? Inasmuch as the family has had no opportunity to name its problem or its goal, its members may not grasp the object of performing a task that may seem totally unrelated to their distress. In addition, the rapport established during joining may be diluted by the family's confusion and boredom.

A less risky step than moving to problem exploration, and one that is more obviously pertinent than most standardized tasks, is to ask the family members to specify their goals. Experienced clinicians know that such a task is often extremely difficult to accomplish. Family members are much more likely to be obsessed with their distress than they are to have specific objectives in mind. Furthermore, many members are eager to complain to the therapist and to attack one another. In short, they may not be in a mood to be constructive. Some therapists think that unless one starts with and maintains a focus on "the problem," the family will lose its motivation. Undoubtedly this is true for some families. Nonetheless, seeking out family goals at this point in the evaluation has so much to recommend it that we think it is the best next step in most situations.

One of the virtues of making goal statements is its positive quality as an activity. Emphasizing what the family desires in the future, rather than the problems it is experiencing in the present, tends to circumvent blaming,

discouragement, and deflation of the family's self-confidence. It also avoids giving the family an opportunity to attack a scapegoat; if this occurs at an early phase of the evaluation process, it can alienate the scapegoat and make other family members feel guilty and insecure. If the discussion of problems is subordinated to the subject of goals, then the troubled areas will reveal themselves less offensively as the unspoken, but often obvious, obverse of the goals.

A second virtue of stating goals is that it can be accomplished by anyone over the age of 3, particularly if one allows younger children to depict goals that seem trivial and private (e.g., "I want a stuffed bear."). This permissiveness frees older members from an obligation to sound intelligent by being abstract. For example, it allows the father to state that he "wants everyone to help to clear the table after dinner" rather than to state that he seeks an "atmosphere of cooperation." Because eliciting goals is more easily said than done, we offer a few guidelines: First, the instructions should be clear and the task simple to fulfill. For example, the therapist may say, "I am going to give each person a chance to tell me one or two ways the family can be better than it is now. Remember what I said about the rules. You don't have to say anything if you don't want to. But each of you will have a chance if you want it. Who would like to start by saying one way the family could be better?" Second, statements of goals are most helpful when they are concrete enough to be imagined and general enough to have some breadth of meaning. The therapist may need to reframe the young child's overspecificity ("So you want a stuffed animal, something warm and cuddly like a stuffed animal."). The therapist may also lead adults from the general toward the specific ("Could you try to tell us what would happen if, as you say, harmony were to prevail?"). Third, the therapist should encourage each family member to turn any complaint or blaming into a goal. For example, a complaining sibling may be told, "You don't want your brother to hit you. OK. What do you want him to do instead?" Fourth, the therapist should remove all pressure for comprehensiveness, as in this example: "You don't have to say all the ways things could be better now. You'll have plenty of chances to tell me about other things later." And fifth, the therapist should not pressure the family members for completion of the task if (1) they seem incapable of putting anything in a positive frame, due to an overwhelming fixation on their pain and their problems; (2) the task seems to undermine their motivation—for example, if a peripheral father says, "How can we talk about this junk when these savages are just destroying the family?"; (3) the family is experiencing overwhelming stress (e.g., due to the recent death of one of its members) and it seems insensitive or disrespectful to talk about "desires"; or (4) the resistance to the task does not yield to gentle encouragement, even if the reason for the resistance is obscure. In such situations the therapist should move on to problem exploration—for example, by saying, "I don't think it was such a good

idea for me to ask you first about what you want. What I think we should do instead is find out what it is that you are not happy about in your family. Afterward we can talk about what will make you happier."

Goal Enactment

Once goals have been stated, the therapist can direct enactments of those goals. Ideally, a separate enactment will be directed for each member's goal. The enactment of goals has distinct advantages. First, it promotes specificity and concreteness of objectives. When it is demonstrated what the family might look like and sound like when the goals are met, everyone can have exactly the same image of what each person wants. That image will be "worth a thousand words." Second, it gives the family members a chance to rehearse how they want to be without necessarily feeling pressured to change in that way. For example, the therapist may say, "Remember how your son showed us the way he wanted you to help him make things. Of course, this may not have anything to do with the problem you came about, and it may not be anything that we are going to work on in therapy, but let us complete the exercise anyway. So sit next to him and show him how he can put puppets on his hand as an example of your helping." After they do it, the therapist may say, "Johnny, is he doing it all right? Is this what you meant?"

Suppose Johnny's goal is for the family to get him a stuffed animal. The therapist can encourage enactment by saying, "Johnny, it's OK not to be fancy. You think the family would be better if you had a stuffed animal. That's a fine goal. Here is a pillow. Make believe it is a stuffed animal. Can you show me who would give it to you, what you would to with it, and how the family would be better if you had it? Let's start with who would give it to you." If he points to his mother, the therapist may say, "Make believe you are your mother and that your mother is you. Give her the animal just the way you would want her to give it to you."

In some situations the therapist may decide against separate enactments and may instead design and direct the family in a single role-played minidrama that incorporates the goals stated by each family member. The following vignette provides an example of such an integrated enactment:

George, 12, the index child, seems depressed to his parents and teachers. In the second phase of the interview, each family member states goals:

> FATHER: I want George to show more enthusiasm. It would demonstrate that he isn't depressed.
>
> MOTHER: I want mealtimes to be calmer, with no fighting, and I'd like the boys to help me with preparing the meal. After it is served, everyone should discuss current events while we eat. I want Alice to sleep through the night instead of having nightmares and coming to my bed.

BILL (14): I want George to be more enthusiastic.

GEORGE (12): I wish Bill would want to do more with me.

ALICE (4): I want not to be afraid at night. I want to feel good so I can sleep at night.

The therapist constructs and directs a scene in which the family's goals have been achieved. The therapist does this by explaining privately to each family member the role he or she would like that person to play. For example, Bill is instructed to show interest in George's ideas. No family member knows what the whole scenario will look like until it is played out. The enactment proceeds as follows:

The whole family is at home. George has arrived and is expressing to his father and Bill wild enthusiasm about his recent visit to a computer fair. Bill says he is eager to go there with George the next day. The mother, with that cue, announces dinner and thanks the boys for preparing it. During dinner the father mentions a newspaper article about someone who attempted murder and was released on $500 bail. Everyone has something to say about the event.

The therapist dims the lights for bedtime. Alice lies down on a couch with a blanket, as if safe in her bed. The therapist assures her that she is very comfortable. She now overhears the rest of the family talking softly about how nice it is that she has been sleeping through the night recently. Her father jokes that the electric bills are lower; her mother and both brothers comment on how good it is that they can all get a good night's sleep now, and that Alice is so grown up.

When the therapist turns up the lights and announces that it is morning, Alice bounds excitedly from bed and rushes to her mother to tell her about the wonderful dream she had that night about swimming without her water wings. When the enactment is over, the family members seem lighthearted and pleased with themselves. Following some further exploration of family problems, the therapist tells them that there is no need for further meetings at this point. At follow-up 4 months later, George's and Alice's symptoms have disappeared. The father seems depressed and unenthusiastic about his work, however; he has been putting off a career decision for a year. It may be appropriate to suggest that the parents come in for one follow-up session without the children. If necessary, a recommendation and a referral for individual therapy to focus on the father's depression and career issues can be offered at this time.

Problem Exploration

By the time the problem exploration phase occurs, the therapist already has a great deal of information. Family members have discussed their strengths, expressed their wishes, and experienced their goals psychodramatically. Thus, this phase can begin with a sense that the therapist is

informed and the family feels understood. Furthermore, the therapist is in a good position to determine which manner of problem exploration will be most likely to succeed with the family.

The object now is for the therapist to fill in whatever gaps of information remain. By the end of the problem exploration phase the therapist should have answers, or at least good hunches, about the following:

1. Whether there is a problem requiring urgent attention
2. What principal cycles or redundant sequences of behavior are associated with the family's distress and/or developmental impasse
3. When and in what context these problems emerge
4. What attempts have been made to solve problems, with what results
5. What belief systems seem to prevent the family from discovering a solution

The problem exploration phase involves two steps.

Step 1. In most instances, this phase should begin either with a relatively nonthreatening but revealing family task, or with a series of descriptions and enactments that depict the "dreaded future" (i.e., what the family members fear might happen if things do not improve). Nonthreatening standardized tasks are a good choice when the family has preschool children who can easily and fruitfully join in such activities, or when it is already obvious what the family most fears about the future. The dreaded future task may be selected with families in which there are older children and with families whose fears about the future are obscure.

Examples of nonthreatening tasks are the kinetic family drawing task, in which each family member sketches a picture of the family doing something, and a building task, in which family members make a structure together, using blocks. Such tasks and a brief open discussion of them will ordinarily provide the therapist (and the family) with abundant information without creating much stress.

The second alternative can be painful, but is almost always worth the strain. In role-playing the dreaded future, the same principles and practices of enactment apply as in the enactment of an improved future. The principal virtue of enacting the dreaded future is that it provides detailed information about the family's current problems without blaming anyone for past or current misdeeds. It is a nightmare fantasy, not a damning, well-documented indictment. A secondary benefit is that explicit visions of a dreaded future defeat denial and stimulate motivation for change.

However, in a few cases, the therapist may feel that such enactments are implicitly so maligning to a scapegoated family member that the therapist may wish to give each family member an opportunity to set the re-

cord straight. Ordinarily, however, it is best to allow these enacted fears to stand unchallenged and to remind the family that these worries are simply concerns about the future and not portrayals of actual current or past events. If the therapist does permit protests about "unfair representations," then corrections should be briefly and simply stated and not pursued unless they seem to be a fitting subject for the second step of this phase.

In the following vignette, fears about the future were of paramount concern:

Only a few symptoms of anxiety existed at the time the family sought therapy. The mother requested a consultation for herself and her anxious 3-year-old daughter, Beth, who in the next few weeks would be facing several events, each one of which the mother felt Beth could handle; in combination, however, these events threatened to overwhelm the little girl. Beth was to witness her (single) mother giving birth to a sibling; lose a grandparent to illness; visit her (divorced) father, who had just moved to another city; and face a few other new and potentially frightening experiences.

At first the mother played Beth going from one event to the other, getting increasingly frightened and flustered. Beth laughed, but showed interest and curiosity. Beth said she would like to try playing out these occurrences. The therapist suggested that she use toys and puppets to enact her role in each event, in the order in which the events were likely to occur. The therapist used different parts of the room to symbolize each event and walked Beth through them in sequence.

Beth then reenacted each one by herself, with a sense of relaxation and mastery over her anticipated itinerary. It was like learning a nursery rhyme.

Step 2. The second step of the problem exploration phase involves focused questioning of family members by the therapist or further simple enactments designed to gather any remaining data the therapist needs to arrive at a provisional assessment of the family predicament. This step is likely to be brief, as few gaps of crucial information are apt to persist.

If one uses verbal inquiry at this point, simple and direct questions may be perfectly adequate. However, therapists familiar with circular questioning (Penn, 1982) ordinarily use that mode of investigation for the extra richness of information it gives to the therapist and the family.

Some therapists prefer to use action "probes" in this phase. These tasks, given by the therapist to the family, are designed to test the therapist's hypotheses about what age-appropriate, constructive behavior patterns are outside the family's repertoire. For example, if the family appears to have difficulty coming to a consensus, the therapist might say, "Talk together about where to eat on the way home." No matter how the family

performs, it can be congratulated for completing the task. Even if the family members talk irrelevantly and angrily, pay no attention to each other, and in general fail to make any progress with the task, the therapist can still say, "Thank you for doing what I asked you to do; it was helpful." It is helpful: it confirms a hypothesis about the family's limited repertoire of problem-solving techniques and provides information about how the family failed in its attempts to carry out the task.

Sharply focused directed enactments may also be helpful in this stage of the problem exploration. The following vignette provides an example of problem exploration through simple enactments of the past and present and demonstrates the value of our earlier recommendations that the consulting room be large and flexibly furnished:

The mother and her three children from a previous marriage; the father and his four children from a previous marriage; and the father's mother, who lived with the family, all attended the session. The presenting problem was hostility between the father's 8-year-old son and the mother's 9-year-old son, who shared a bedroom. Problem exploration in this case involved, among other things, investigating the costs to the children of the new "blended" family. The therapist said, "Let's go back to see what your households looked like 2 years ago [before the meeting of the parents]." He asked each original family to use separate sides of the room and a collection of pillows to map out its home and to depict relationships within each of the original families through enactments of typical activities. Then, in a third part of the room, the family members laid out their current living arrangements, with children grouped not by family of origin, but by age and sex. When asked to depict relationships in the blended family, it was clear to everyone that an enormous amount of strain and conflict had arisen from the abrupt reshuffling of roommates and the abandonment of each separate family's traditions in favor of a new image created by the new couple. It was evident that the children were still loyal to the values of their original families and were struggling mightily against the couple's new family image.

Advice to the Family

In the final phase of the interview, the therapist should offer the family a synopsis of findings and a recommendation about further evaluation or treatment.

No therapist should feel obligated to deliver this statement without pause for private reflection. There is no harm done if the therapist leaves the room for a few minutes to prepare this summary statement. A therapist who is not working with a team should at least give him- or herself (and the family) the benefit of self-consultation.

The summary statement should include the following:

1. A respectful acknowledgment of the family's strengths
2. A brief summary of the family's wishes and fears
3. One or two hypotheses that benignly connect the family's current problems with well-intended and wise traditional (but currently ineffective) family patterns of thought and behavior
4. A clear recommendation for future action, with a very brief rationale for it

CONCLUSION

Our aims in this chapter have been to encourage therapists to recognize the virtues of including whole families in family therapy sessions, and to provide practical guidelines and techniques to support their attempts to do so. We expect that as therapists increasingly venture into this challenging area of practice, their work will become more rewarding.

Many of our recommendations speak directly to the issue of "active engagement." We recommend that consulting rooms be large and flexible, *or at least flexible,* so they can function as stages on which wishes, fears, and factual family interactions can be played out. We recommend that materials be offered that encourage intelligible play—play that can be interpreted not only by the therapist, but also by the family members. We recommend assessment and intervention techniques that are as boredom-resistant as possible: Who will be bored watching him- or herself being played by another family member? We recommend clarity of rules and expectations—boundaries within which truthfulness can freely, safely, and actively unfold before the eyes of family members and therapist alike. And, finally, we offer a model for assessment interviewing to guide clinicians who feel eager but unsure about conducting engaging and effective family sessions with children.

NOTES

1. *Editor's note*: Some family therapists choose to see the whole family first (including siblings). Their argument is that this is a way of avoiding having information given about the children without their being involved. In some therapists' view, this approach of the therapist to get information from the family encourages the children to be more engaged in the therapeutic process and, perhaps, in the family process. This approach, however, challenges the therapist not to let the family focus on the identified patient in a way that makes him or her of a scapegoat.
2. *Editor's note*: It is good for the therapist to call the parents by their titles (e.g., Mr., Mrs., Dr.), rather than by first names, to emphasize their different status.

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