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1

Expanding the Possibilities

A Collaborative Strengths-Based Brief Therapy Approach with Children

What moves men of genius, or rather what inspires their work, is not new ideas, but their obsession with the idea that what had already been said is still not enough.

—EUGÈNE DELACROIX

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Introduction: Myths about Children and Therapy

President John F. Kennedy once said: "The greatest enemy of the truth is not the lie—deliberate, contrived, and dishonest—but the myth—persistent, pervasive, and unrealistic" (in Dawes, 1994, p. vii). Therapists hold many sacred cow beliefs about which methods and treatment approaches are best suited for children. Child therapists argue that family therapy approaches fail to attend adequately to the developmental concerns and intrapsychic conflicts of the child client. Family therapists, on the other hand, maintain that the child's symptoms indicate such family dysfunction as pathological structures or problem-maintaining interaction patterns. Another widely held belief among therapists is that treatment with children must be long-term. In this chapter, I first dispel some commonly held myths about children and therapy and demonstrate why a collaborative strengths-based brief therapy approach can be an effective treatment model for clinical work with children and their families. I then present key findings from research on resilient children and the growing field of positive psychology that provide empirical support for the major therapeutic tools, strategies, and key elements that promote change with this therapeutic approach. Finally, I follow with an

overview of the major components of the collaborative strengths-based brief therapy approach for children.

"Young Children Should Be Excluded from Family Therapy Sessions"

It is not uncommon for family therapists to instruct parents either to leave their youngest children at home with a babysitter or to place them in a supervised play area in the office waiting room. Some family therapists believe that including young children in family sessions could be "psychologically harmful to them" (which is a concern also raised by some parents) or that they might be "highly disruptive" during the session. Many believe that young children would be unable to participate in session discussions or understand what is talked about, anyway, because of their "developmental limitations."

However, there are several good reasons for including young children in family therapy sessions. Through young children's play and artwork we can gain access to family conflicts less accessible through verbal communications (Bailey, 2000; Zilbach, Bergel, & Gass, 1972). Often children's play and artwork are metaphors for how they view themselves and significant relationships in their families. Eliciting feedback from the parents and older siblings of the young child about his or her play and artwork can open up avenues for challenging outmoded family beliefs and unhelpful parent–child interactions. Keith and Whitaker (1994) maintain that "play is the medium for expanding the family's reality" (p. 194). Young children inject spontaneity and playfulness into family sessions. The young child can serve as a co-therapist in teaching his or her parents how to play again. Finally, young children's presence in family sessions affords the opportunity for the therapist to model positive, nurturing, and playful interactions for the parents.

"Traumatized Children Will Grow Up to Be Emotionally Flawed Adults"

Undoubtedly, some children who have been traumatized by various forms of parental abuse or who have experienced painful losses are subject to emotional scars that could possibly haunt them for the rest of their lives. The trauma literature is filled with examples about the deleterious effects of traumatic events on a child's individual and interpersonal functioning. Yet, over the past few decades there has been surprisingly little discussion about the growing body of resiliency research that has identified children who experienced multiple traumatic events in their lives and yet managed to grow up to be well-functioning adults. As Garmezy (1991) has pointed out, the resilient individual is characterized by "the maintenance of competent

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functioning despite an interfering emotionality" (p. 416). In commenting on some widely held beliefs in the sex abuse treatment field, Trepper and Barrett (1989) note that "the belief that sexual abuse will lead to severe emotional problems has been the cornerstone of all therapy. Most therapists probably believe this without hesitation, and probably justify some of their most intrusive therapeutic measures on it. The research on the long-term effects of child sexual abuse has been quite mixed, however" (p. 11). Garmezy (1993) also argues that there are not enough empirically based longitudinal studies of long-term outcomes of child abuse cases to support the widely held belief that an abused child will grow up to become an adult abuser.

Here I present two major studies conducted with trauma survivors who "beat the odds" and grew up to be well-functioning adults.

Moskovitz (1983) conducted an exploratory study with a group of Holocaust survivors to determine how they coped with their hellish experiences in the Nazi concentration camps during World War II. None of her subjects succumbed to suicide attempts, alcohol or drug abuse, or psychiatric disorders. She noted that "their hardiness of spirit and their quiet dignity are part of this persistent endurance" (p. 233). Moskovitz further added: "Despite the severest deprivation in early childhood, these people are neither living a greedy, me-first style of life, nor are they seeking gain at the expense of others. None express the idea that the world owes them a living for all they have suffered. On the contrary, most of their lives are marked by a compassion for others" (p. 233).

Festinger (1983) followed 277 children in New York City who were placed in foster care early in childhood until young adulthood. Many of these children were emotionally and physically abused, were abandoned, had a mentally ill or drug-addicted parent, or lost a parent through death. Approximately 69% of her sample had been in three to four foster homes or institutions as young children. When comparing all 277 of these young adults to a sample of subjects from a national survey conducted by the Institute of Social Research at the University of Michigan, she discovered the following: although the foster care subjects showed lower scholastic achievements, their employment rates, health and symptoms status, and personal evaluations of their feelings, future hopes, and current sense of happiness were similar. Festinger noted that her foster care subjects were generous contributors to the study and exhibited a willingness and openness to discuss their lives in the hope that it would help others.

What these two studies did not mention was that each of the subjects possessed a unique set of protective factors that helped insulate each one from the onslaught of multiple stressors and adverse life events throughout his or her childhood. Without these protective factors, such as social competence and nurturing support systems (Garmezy, 1994), the research subjects'

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adult lives might have turned out differently. Later in this chapter, I discuss further the role of protective factors in the adaptation process as well as how resiliency research can inform our clinical practices.

When working with children who were traumatized, we need to empower them to become masters of their own lives. We can do this by conveying an optimistic attitude, capitalizing on their competency areas, respecting their defenses, and giving them room to tell their painful stories when (or if) they are ready to do so. As therapists, we need to be sensitive to the fact that our theoretical maps and the way we interact with our clients determine what we see. If we operate from a deficit-oriented model, we inevitably see deficits and become expert repairmen and -women. By capitalizing on our young clients' strengths and resources and what is "going right" in their present lives, we can help these children create their own positive self-fulfilling prophecies.

"Children Should Be Seen and Not Heard in the Treatment Planning and Problem-Solving Process"

More often than not, children are not given a voice in their own treatment or school educational planning. Typically, when a family presents for therapy, the parents' goals automatically become the focal point for determining treatment objectives without seriously exploring with the child what his or her goals or expectations might be, such as what specifically the child would like to see changed in the parents' behavior. We see this phenomenon a great deal even in child abuse cases, where the treating therapist, child protective worker, and other involved representatives from larger systems typically determine the treatment goals and treatment plan for the child and family. Often at multidisciplinary school staff meetings, children are altogether excluded when an individualized education plan (IEP) is being developed for them, and, if they are "lucky," they will be invited in at the end of the proceeding to hear what direction their school year will take in terms of special services or placement. Not only do the children have no input in the final individualized education plan, but also they have no opportunity to give any feedback on the school psychologist's case study evaluation results, which are typically discussed in the multidisciplinary staff meeting.

When working with children and their families, I invite the child to share his or her goals and expectations for the therapy. Some children may have a specific goal in mind for their parents (e.g., to "yell" less). I believe it is essential to pay heed to both the parents' *and* the child's goals or objectives. Also, I explore whether the children are having any special problems with siblings or particular teachers with whom they would like me to intervene. To help take the onus off the child client's being labeled by the parents and others as the "bad kid," I recommend to the parents,

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as an experiment, to carefully observe for 1 week the angelic "good kid's" behavior when he or she is around the client. Frequently, parents discover that their angelic child is a master at pushing their so-called problem child's buttons. This therapeutic experiment helps to show the parents that the problem is essentially *relational* and challenges their belief that the problem is solely confined to the one targeted child. Finally, whenever possible, I try to include the child in any collaborative meetings with school personnel and involved helpers. By hearing their young voices directly in these collaborative meetings, school and other helping professionals learn firsthand what the child's unique needs, attributes, and best hopes are, in addition to revisiting what has and has not been helpful in their interactions to date with him or her.

In an exploratory study with children who had received family therapy, researchers discovered from the children themselves that they expected to be fully included in family sessions and to have an active voice in discussions and participate meaningfully in the problem-solving process. The children also appreciated therapists who displayed warmth and concern toward them (Stith, Rosen, McCollum, Coleman, & Herman, 1996). Research of this kind provides empirical support for the importance of giving children a significant voice in their own treatment.

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"Severe and Chronic Child Behavioral Difficulties Will Require Big and Complex Solutions"

In an earlier work (Selekman, 2005), I discussed the evolutionary process through which cases become "difficult." Typically, the so-called difficult case keeps receiving "more of the same" type of treatment (Watzlawick, Weakland, & Fisch, 1974), and the child's and family's problems become further compounded and exacerbated while on the treatment circuit, collecting a variety of labels out of the DSM-IV-TR (the text revision of the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*; American Psychiatric Association, 2000). In commenting on the labeling process, Wittgenstein (1963) warned us against prematurely treating as already complete phenomena that are essentially incomplete human activities still in progress: "If you complete it, you falsify it" (p. 257). In other words, once a child is labeled as having a particular problem or disorder, suddenly we find that there is no other way of thinking about this child—past, present, or future!

When working with children and families that have experienced multiple treatment failures, it behooves us to explore with them what they disliked about former therapists and therapies, so as to avoid making the same kinds of mistakes. I like to empower these families by treating them as experts, asking them the following types of questions:

- "You have seen a lot of therapists before me; what did they miss with your situation?"
- "What didn't you like about former therapists?—so I don't make the same mistakes."
- "If I were to work with another family just like yours, what advice would you give me to help that family out?"
- "If you were to work with the perfect therapist, what would he or she do that you would find to be most helpful?"
- (*with clients labeled "noncompliant"*) "On your way to my office, did you think about all of the possible ways I could screw up your case? What are some of those ways?"

It is also helpful with therapy-hardened families to negotiate small but achievable goals, with the family members deciding what they want to work on changing first. With some of these families, past therapists' goals may have driven the treatment: either the therapists had no idea what their clients' goals were, or the clients' goals were too ambitious, such as trying to change too many symptoms simultaneously. When the latter is the case, I find it most useful to break up the family and work with family subsystems or individuals separately (Selekman, 2005).

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"The Therapist Is More of an Expert on Parenting Than the Child's Parents"

Many therapists adopt a privileged-expert attitude with the parents and children with whom they work. It is hard not to fall into this trap. The more specialized training and knowledge we secure in a particular therapy approach, the more confidence (verging on overconfidence) we come to have in our therapeutic abilities and therapy models of choice. As Palmarini (1994) cautions us, "We need to be wary of our overconfidence, which tends to be at its greatest in our own area of expertise and where it can do the most damage" (p. 119). There are many popular parenting models that therapists have adopted as their road maps for parent training, such as parent effectiveness training (PET; Gordon, 1970), systematic training for effective parenting (STEP; Dinkmeyer & McKay, 1989), and Active Parenting (Popkin, 2007). Some child therapists believe that they are better equipped than the child's parents to provide their young clients with missing "selfobject functions" (Kohut, 1971) or to help them resolve their intrapsychic conflicts. The same is true with play therapy, as the parents are rarely included in the child's play or art activities.

It is my contention that our main expertise as therapists should be directed toward eliciting the parents' expertise. Any past successes that the parents have had at resolving other behavioral difficulties can be used as models for present and future successes. In all problematic parenting

situations, there are times when the parents are managing their children's behaviors well and are enjoying their tough jobs. Like a Columbo or Miss Marple detective, we need to inquire about what specifically parents are doing during those nonproblem times that is working for them. These key parental problem-solving and coping strategies can serve as building blocks in the solution construction process. Similarly, taking the time in the first family session to find out from the parents what their strengths and talents are in their work roles can provide therapists with valuable information that they can utilize in developing potential solution strategies. Finally, why not include parents in the child's in-session play and art therapy activities? Doing so can help reduce family stress, improve family communications, and teach parents and children fun ways to resolve conflicts and problems.

Superkids: How Resiliency Research Can Inform Our Clinical Practices

In speaking out against the "Diseasing of America" (Peele, 1985) trend in the media and in the world of mental health care—which continues into the present, owing to popular talk shows that devote whole programs to the "disorder of the day"—Wolin (Wolin, O'Hanlon, & Hoffman, 1995) has argued that "we need a list of strengths as powerful and as validating as the florid vocabulary of diseases found in DSM-IV to combat our national obsession with pathology" (p. 24). Wolin (Wolin & Wolin, 1993) and a group of psychologists and psychiatrists have been studying high-risk children's psychosocial competencies and resourcefulness over the past three decades. These researchers found that, when faced with adversity and stressful life events, many of the children in their studies consistently "bounced back" quickly and "beat the odds" (Anthony & Cohler, 1987; Haggerty, Sherrod, Garmezy, & Rutter, 1994; Wolin & Wolin, 1993).

Table 1.1 provides an overview of the three categories of key protective factors that are found in these researchers' studies of high-risk children reared in poverty and high-stress family environments characterized by violence, parental alcoholism and substance abuse, divorce, and parental mental illness. Following this overview, the discussion turns to how to develop, enhance, and utilize these key protective factors in our therapeutic work with children and their families.

Effective and Creative Problem Solvers

One of the most frequent findings in all the reviewed studies with high-risk children was that these children had strong problem-solving abilities. These children were described as "resourceful," "creative," and "acting"

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TABLE 1.1. Key Protective Factors of Resilient Children

Individual factors	Family factors	Extrafamilial support factors
Optimistic explanatory style	Caring and supportive parents	Nurturing support system (relatives, friends, teachers, neighbors, and inspirational significant others)
Good sense of humor	Strong parent–child relationships	Church involvement
Self-efficacy	Low levels of family conflict	Successful school experiences
Strong social skills	Optimistic parenting explanatory styles	
Cognitive competence		
Good-natured temperament		
Pronounced self-sufficiency		
Robustness		
Sense of coherence		
Perseverance		
Involvement in creative activities		
Intelligence		
Strong problem-solving skills		
Good management of emotions		
Keen sense of self-awareness		

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rather than "reacting" to the problems and crises they faced (Anthony, 1987; Garmezy, 1981, 1994; Masten, Best, & Garmezy, 1990; Masten & Garmezy, 1985; Werner, 1987a, 1987b; Werner & Smith, 1982, 1992; Wolin & Wolin, 1993). Many of these children viewed problems as challenges they were confidently prepared to face and master—a finding in studies on children deemed optimistic (Diener & Dweck, 1978; Dweck, 1975; Seligman, Reivich, Jaycox, & Gillham, 1995). As a way of coping with crises and problems, some of these children would seek solace by going to church, spending time with a close friend or an inspirational other, or engaging in sports or other recreational activities (Anthony, 1984, 1987; Masten et al., 1990; Wolin & Wolin, 1993).

Anthony (1987) has identified two types of cognitive competence displayed by resilient children: *constructive competence* and *creative competence*. Constructive competence is characterized by a practical and concrete approach to tasks and problem solving. These children are independent and self-confident when carrying out tasks. Creative competence is demonstrated by the child's ability to move from practical ways of solving problems to more abstract and novel ways of problem solving.

In applying this important protective factor to clinical practice, in the initial family assessment session I explore with the child and his or her parents what the child has done in the past and does presently to resolve problems or better cope with them. I have some children visualize memorable successful problem-solving experiences and utilize these movies of success to empower them to resolve their presenting problems. It is also helpful to find out from the parents what they have done successfully in the past to help the child better cope with life stressors and resolve difficulties. These successful problem-solving strategies can be used in the current problem area. Sometimes I have a child create a *victory box*. He or she records on paper any personal triumphs, achievements, and problem-solving efforts in school, at home, in sports events, or with the creative arts, including the steps he or she took to achieve these wonderful accomplishments, and then places these slips of paper in the box. The victory box serves as a storehouse for blueprints of success and mastery for the child and his or her family.

If a child is presented by his or her parents or the referring person as having "poor problem-solving abilities," I still explore with the child and his or her parents what interests, talents, and skills the child has that I might be able to further activate. For example, if the child has a strong interest in science and performs well academically in this subject area, I have the child identify his or her favorite scientists and inventors and discuss how they solved problems. I then ask the child to adapt some of these well-proven problem-solving strategies to experiment with the problems he or she faces. Role playing the child's problem situation can also be useful as a skill-building technique for teaching the child new problem-solving strate-

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gies. However, it is even more effective to include the child's identified "pal" in the role-play activity, as the friend may be able to offer and model more effective problem-solving strategies than the therapist could provide.

Strong Social Skills

Another important protective factor for resilient children is their strong social skills. Many of the researchers who studied these high-risk children were struck by the children's knack for establishing and maintaining relationships with peers, neighbors, clergy, and other adults. Not only were these children naturals at establishing support systems for themselves, but also they could reach out with ease to a friend, parent, or other adult for support in times of crisis (Anthony, 1984, 1987; Garmezy, 1994; Masten et al., 1990; Kauffman, Grunebaum, Cohler, & Gamer, 1979; Wolin & Wolin, 1993). Their solid assertiveness skills were an important strength that helped shield them from becoming clinically depressed (Garmezy, 1981, 1994; Hauser, Allen, & Golden, 2006; Masten et al., 1990; Masten & Garmezy, 1985; Seligman et al., 1995). In his St. Louis Risk Research Project with inner-city African American children, Anthony (1984, 1987) found that many of these children sought out and established a relationship with a charismatic or inspirational person in their community who "turned them on," sustained them, and continued to have long-lasting effects on them throughout their lives.

Most of the researchers observed that the resilient children's social competence served to help build their self-esteem and contributed to their success in school (Garmezy, 1994; Masten et al., 1990; Werner & Smith, 1982, 1992). Most of the emotional needs for some of the resilient children in these studies were met through their social involvement with concerned neighbors, teachers, clergy, and friends' parents.

Clinically speaking, we can capitalize on a child's strong social skills by incorporating his or her close friends, inspirational others, and other concerned adults in the treatment process as consultants. These consultants may offer the therapist, the child, and his or her parents some useful ideas about how to solve the presenting problem and better cope with life stressors. For children who have poor social skills, we can use role playing to teach assertiveness skills. The child's friends can be used as participants in the role-playing exercises and can serve as a natural relapse prevention support team between family sessions (Selekman, 2005, 2009).

Supportive and Responsible Caretakers

Most research on high-risk children challenges the widely held belief among social scientists and mental health professionals that these children lack

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a caring and responsible adult in their lives. In fact, many of the studies reviewed indicated that these children received considerable attention from responsible caretakers in their early years of development and throughout their childhood. Even children who had a mentally ill, alcoholic, or drug-impaired parent described times when their parent was very loving and supportive and met their needs (Anthony, 1987; Bleuler, 1978; Kauffman et al., 1979; Wolin & Wolin, 1993). In some cases, a relative, an adult friend of the family, or the nonsymptomatic parent assumed the main caretaker role for the child. Kauffman et al. (1979) observed in their study that nonsymptomatic parents played a critical role in helping their at-risk children function and cope well with family stressors. Many of the supportive and responsible caretaking adults in the studies maintained optimistic parental explanatory styles (Seligman et al., 1995). These parental figures displayed unconditional positive regard, were flexible, modeled the importance of being optimistic when faced with life's struggles, and taught their children how to separate one isolated failure from other experiences and to challenge their pessimistic views (Murray & Fortinberry, 2006; Anthony, 1987; Bleuler, 1978; Garmezy, 1994; Kauffman et al., 1979; Wolin & Wolin, 1993).

In the clinical arena, this research finding provides empirical support for educating parents about the importance of adopting an optimistic parenting style and demonstrates how such education can greatly influence their children's optimism and behavior when they are faced with stressful life events (Murray & Fortinberry, 2006). In fact, Seligman and his colleagues (1995) found in their Penn Resiliency Research Project that both parental and teachers' optimism serves as a key protective factor in reducing the risk of children's developing difficulties with depression and anxiety. Furthermore, the researchers also found that teaching the children in their study *disputation* skills—that is, specific ways of challenging self-defeating and irrational thoughts triggered by negative and stressful life events—they were better able to develop and maintain an optimistic mindset, to avoid experiencing these emotional difficulties, and to perform better academically than the control group did in the study. Assigning parents observation tasks to keep track of what the child does that is "right" and responsible, asking questions about past successes, and having the parents visualize positive treatment outcomes can help create a therapeutic climate of optimism for the child and his or her family. For families that tend to be overly focused on negative developments, I immediately assign the construction of a *compliment box* (Selekman, 2006, 2009). On a daily basis, family members are responsible for writing on slips of paper one or more compliments for other family members and placing them in an old shoebox with a slit in the top. At dinnertime, family members can take turns blindly reaching into the box and read aloud each other's compliments on the slips of paper. The

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compliment box system helps to reduce blaming and negativity in the family and creates a more positive atmosphere in the home. Finally, grandparents, other significant extended family members, and close friends from the child's social network can be used as expert consultants in sessions and for added support between visits.

The good news is that children—despite being raised in high-risk family and social environments—can and do survive adverse life experiences. Some children are born naturally resilient, while others are quite skilled at creating nurturing support systems for themselves outside their families. The research on resilient children has uncovered many ways that we, as therapists, can help strengthen family relationships and help children find strength and success beyond their families.

Positive Psychology: Studying What Is *Right* with People and Empowering Them to Flourish in Their Lives

In common with solution-focused brief therapy, "positive psychology" mainly emphasizes what is *right* with people. Martin Seligman, Mihaly Csikszentmihalyi, Christopher Peterson, and Barbara Fredrickson are the major pioneers and leading researchers of this revolutionary new movement focused on wellness in the field of psychology (Fredrickson, 2006, 2008, 2009; Kashdan, 2009; Snyder & Lopez, 2007; Peterson, 2006; Peterson & Seligman, 2004; Keyes & Haidt, 2003; Seligman, 2002). These researchers asked themselves, "Why are we not studying people who are flourishing in the world and learn what their secrets are for having meaningful, productive, and highly satisfying lives?" Peterson and Seligman (2004) took it a step further and identified in their research 24 human strengths and 6 major virtues. As part of their intensive effort to identify and define these strengths and virtues they carefully reviewed the written work of great philosophers, spiritual leaders, and historic figures. Peterson (2006) developed two instruments that can be accessed online (at *www.viastrengths.org*) designed to identify an individual's top-five *signature strengths*, permitting him or her also to print out in order of potency the remaining 19 strengths. The adult version of this questionnaire is called *Values in Action (VIA) Classification of Strengths*. The older child and adolescent version of this questionnaire (which is more streamlined) is called the *Inventory of Strengths for Youth*. In my clinical practice, after building a relationship with new clients, I have both parents and children (age 10 or older) answer the questionnaires online and bring in to our next session their respective printouts identifying not only their top-five signature strengths but also the order of the remaining 19 strengths. The benefit of answering these questionnaires are threefold:

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1. We learn about key signature strengths that clients may not have identified at pretreatment or in their first sessions, which can be both illuminating and empowering to them.
2. We learn about latent strengths that clients can begin to develop and use in all areas of their lives.
3. Once clients' top-five signature as well as latent strengths have been identified, these can be used in co-designing, tailor fitting, and implementing therapeutic experiments to help them achieve their goals.

Cszikszentmihalyi (1990, 1997), in studying artists and other professionals immersed in their work and feeling most productive, observed that they all shared the same common feeling, which he called "flow." It was during this segment of their work experience that the professionals lost track of time and were totally oblivious to anything else occurring in their immediate surroundings. Similar to Buddhist monks who have meditated for decades, when these professionals reached their deepest meditative states they experienced a sense of timelessness and nirvana, and they consistently reported that they did their best work while in this flow state. In my work with children, I want to know what their key flow state activities are and have them increase their involvement in them if both their parents and they think this would be a beneficial thing to do, particularly as a strategy to cope with the stressors in their lives. Flow state activities can take many forms, including building models and other constructs, playing an instrument, dancing, or doing artwork.

Fredrickson (2006, 2008, 2009) has developed the *broaden-and-build theory of positive emotions,* having found in her research that positive emotions both broaden people's ideas about positive actions and open their awareness to a wider range of thoughts and actions. Positive emotions open our minds and hearts to be more present with others, to take more positive risks, and to be better and more creative problem solvers. An added bonus of striving to provide ourselves with daily doses of positive emotion is that it also strengthens our immune systems (Fredrickson, 2009). When working with parents, I have them strive to create positive and upbeat home environments and celebrate their children's daily successes, whether at home or at school. I educate parents on the important role that positive emotions play in helping their children flourish and be better problem solvers.

These positive psychologists have helped develop several therapeutic activities designed to reduce negative emotions, trigger positive emotions, raise happiness levels, maintain an optimistic mindset in the face of adversity and stressful life events, and assist individuals in leading more meaningful and fulfilling lives. Two positive psychology activities I use regularly with children are the *you at your best story* and the *plan out your perfect day*

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exercise (Peterson, 2006; Seligman & Dean, 2003). The first involves having the child write a short story (of three to four paragraphs) about something he or she has accomplished (and of which he or she is proud) either very recently or in the past. In a concrete way, I like to teach children about *agency thinking* and *pathway thinking* (McDermott & Snyder, 1999). By "agency thinking," I mean how the child activates him- or herself to pursue a particular goal or particular objective. Agency thinking can include useful self-talk, visualization, or even inviting one's close friends to help one get fired up—almost like a cheerleading squad. Pathway thinking consists in knowing the right steps to take to accomplish a given goal or objective. After the child writes a you-at-your-best short story of success, I have him or her underline with colored pencils (using two different colors) both their agency and pathway thinking and bring the story to our next session. In reviewing the story together, the therapist helps the child see how he or she could use bits of agency and pathway thinking to perhaps achieve other current goals or to change something else in his or her life.

The "plan out your perfect day" exercise is designed to co-create positive self-fulfilling scenarios with clients. The night before each selected day, the child plans out what his or her most perfect day would look like. This exercise entails deciding what needs to be accomplished, identifying what types of pleasurable and meaningful activities he or she needs to engage in, and whom he or she needs to see or be with that would trigger positive emotions and put him or her in good spirits. The clearer and more concrete the child's road map for success is, the more likely he or she will be able to make most of these things happen, if not all of them. At the end of each day, the child rates the day on a scale from 10 to 1, with 10 being "the best day of my life" and 1 "the worst day of my life" (see Chapter 4 for more details on the rating scale). It is best to have the child engage in this exercise over a 2-week period, thereby providing ample time for both the child and his or her parents to see what patterns emerge (i.e., what activities and people trigger the most positive emotions, resulting in days rated 6 or better; or, conversely, which activities and people need to be steered clear of). On a cautionary note, it is important to let children and their parents know that things happen beyond our control and sometimes despite our best intentions we fall short of our goals or don't accomplish everything we set out to do on any given day. It is important to emphasize that it is the effort that counts and that low-rated days are not a reflection of the child's lack of strengths or willpower. Finally, it is advisable to map out a "Plan B" with the child and the parents. Whenever the child's day begins to take a negative turn, he or she can then spell out the steps that one might take to save the day. By doing so, the child is encouraged to think ahead and will be better equipped to constructively manage the situation and become more resilient in the future.

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An Evolving Integrative Solution-Focused Brief Therapy Model for Children and Adolescents: The Collaborative Strengths-Based Brief Therapy Approach

Like all therapy models, the basic solution-focused brief therapy approach has its limitations with certain types of child and adolescent cases, even after exhausting all the therapeutic options within the model. Having worked with the solution-focused brief therapy model since 1986 and experienced great clinical results using it, I was discovering that there were certain child and adolescent case situations where using the model in its pure form was not leading to the kinds of changes the families desired, even after fostering cooperative relationships with them and negotiating achievable treatment goals. Furthermore, I was also finding myself feeling stifled by the base model's being too formulaic, that I was limited to specific categories of questions and therapeutic tasks and not free to bring in ideas from other therapeutic approaches or to contribute my own creative ideas and therapeutic experiments. Before discussing three clinical case situations in which it may be necessary to expand the basic model and integrate and apply therapeutic ideas from individual and other family therapy approaches, I discuss some of the limitations of the solution-focused brief therapy approach with children.

To begin with, the basic solution-focused brief therapy approach is a "talk therapy," which does not mesh well with young children's natural tendencies to express themselves best through nonverbal means (e.g., play and art activities). Berg and Steiner (2003), however, have begun to break new ground in this area by developing art and play activities for children that are informed by the solution-focused brief therapy approach. Young children are not capable of cognitively understanding such abstract concepts as "miracles" and "goals." Some of these children may respond better to the use of *an imaginary wand or crystal ball* (toy ones can be used as well). The solution-focused questions in general may be incomprehensible or too difficult to grasp for some children, even after the therapist simplifies the wording of the questions. Many solution-focused therapists believe that simply altering parental beliefs and interactions with the child will lead to the latter's changing. This assumption is based on the systems concept of *wholism*; that is, if you change one part of the family system, the other members of the family will change as well (de Shazer, 1985). Most solution-focused therapists, and family therapists for that matter, would not consider the idea that children can serve as the catalyst for changing their parents' and family interactions through the use of family play and art activities. de Shazer (1988) has suggested that therapists should draw from the set of "all known tasks" once they have exhausted all the standard therapeutic tasks typically used within the basic solution-focused model. What he does

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not provide for therapists, however, are recommended therapeutic interventions and strategies from other therapy approaches that may be useful with particular types of children's problems and clinical case situations. I began to ask myself the following question: "Why do I have to stay so loyal to the solution-focused brief therapy approach that I have to wait until I have exhausted all the possibilities within the model before integrating some new ideas or trying a completely different approach?" I started giving myself permission to improvise more and to bring in compatible therapeutic tools and strategies from other therapy approaches. As a result, I began getting better clinical outcomes with some of my toughest child and adolescent clients.

At this point, I present three case situations in which I found it helpful to expand the basic solution-focused model and to be more therapeutically flexible:

1. The parents change their ways of viewing and interacting with the client; however, the child remains symptomatic.
2. The parents' treatment goals are achieved, but the changes in the client are not perceived by them as sufficiently "newsworthy"; thus, their outmoded beliefs about the child and their situation remain intact.
3. Multiple helping professionals are involved with the case, many of whom are highly pessimistic about the client and his or her family's ability to change.

By expanding the basic solution-focused brief therapy model and being therapeutically flexible, the therapist can adequately manage each of these situations. In the first case scenario, mindfulness meditation, visualization, disputation skills training, positive psychology exercises, and family play and art therapy tasks can open the door to a child's inner world and help remove constraints or blocks in affective or cognitive areas of functioning that may be preventing symptom alleviation.

In the second case scenario, there may be family secrets, unresolved traumas and losses, or other family concerns not being talked about, or the therapist may have blocked family members from sharing their long, problem-saturated stories by overemphasizing positive talk in sessions. Two common parental concerns typically voiced in these types of situations reflect either my reluctance to accept and confirm the DSM-IV-TR label to which the parents are committed or my imputed failure to take their child's chronic presenting problems "seriously enough." By asserting that the therapist is not taking their child's presenting problems seriously enough, the parents may be trying to express that they want the therapist to work with their child individually or on a longer-term basis. Open-ended conversational questions (Anderson, 1997; Anderson & Goolishian, 1988a, 1991a, 1991b; Selekman, 2005, 2009) can be used to give family members

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ample space to share their concerns and the "not yet said," such as disclosing a family secret or a painful life event. Another option would be to use a "reflecting team" (Andersen, 1991, 1995) to offer the family a multiplicity of views on their family concerns and difficulties. This alternative could help loosen up fixed family beliefs and open up space for family members to view their situation differently.

In the third case scenario, a therapist hosting a family–multiple helper collaborative meeting or attending a multidisciplinary school meeting may come across as too optimistic or overzealous about reporting the positives in a chronic child case, and group conversations and input from the more pessimistic helpers attending these meetings may be shut down. Therefore, when hosting or attending such meetings, therapists, no matter what their theoretical persuasion, should adopt the Buddhist stance of "don't know mind," which is a true "both/and" perspective (Selekman, 2005). As the hosting therapist, he or she must be able to suspend his or her assumptions about the helpers' and family's concerns to learn to view them as assumptions and not facts, and to hold them in front of the group for all to see (Scharmer, 2007; Selekman, 2005, 2006; Isaacs, 1993). Similar to attending to the concerns of a pessimistic family member, the therapist needs to create a safe space for the pessimistic helpers to voice their concerns about the case. It is important to remember that there are many ways to view a child or family's presenting problems and that consensus in the family–multiple helper collaborative meetings or among school staff is not required in order to have effective group problem solving and to generate new family narratives. Finally, therapists need to view these concerned helping professionals as allies in the treatment process who bring to us and the clients a wealth of strengths, expertise, and wisdom from working with similar children and families in the past that we can tap to cogenerate high-quality solutions together.

A final reason for expanding the basic solution-focused brief therapy model and utilizing a more integrative approach is that such expansion increases our repertoire of interpretation schemes and offers us a broader range of therapeutic options when intervening with clients and their families. Research also indicates that there is compelling evidence for the effectiveness of integrative family therapy approaches for children and adolescents with behavioral problems (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009; Lebow, 2005; Lebow & Gurman, 1996).

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Applying the Collaborative Strengths-Based Brief Therapy Approach with Children

What is unique about collaborative strengths-based brief therapy is that it is a flexible family competency-based model that targets interventions at all levels of the child social realm and logically brings together the best ele-

ments of change-based and meaning-based postmodern systemic therapy approaches. Although my model continues to evolve, it presently integrates the best elements of MRI (Mental Research Institute) brief problem-focused therapy (Fisch & Schlanger, 1999; Fisch, Weakland, & Segal, 1982; Watzlawick et al., 1974); narrative therapy (White, 1995, 2007; Freeman, Epston, & Lobovits, 1997; Epston, 1998; White & Epston, 1990); collaborative language systems therapy (Anderson, 1996, 1997; Anderson & Goolishian, 1988a, 1988b, 1991a, 1991b); client-directed, outcome-informed therapy (Murphy & Duncan, 2007; Duncan & Miller, 2000; Hubble, Duncan, & Miller, 1999); positive psychology (Fredrickson, 2006, 2008, 2009; Kashdan, 2009; Snyder & Lopez, 2007; Peterson, 2006; Peterson & Seligman, 2004; Seligman & Dean, 2003; Keyes & Haidt, 2003; Seligman, 2002; Csikszentmihalyi & Csikszentmihalyi, 2006; Csikszentmihalyi, 1990, 1997); Buddhist mindfulness practices and teachings (Lantieri & Goleman, 2008; Hanh, 1991, 1997, 1998, 2003, 2007); Navajo First Nation healing and teaching practices (Alvord & Cohen-Van Pelt, 2000); cognitive therapy (Seligman et al., 1995); the stages of change model (Norcross, 2008; Prochaska, Norcross, & DiClemente, 1994); the multiple intelligences framework (Gardner, 1993, 2004); interpersonal neurobiological therapeutic ideas (Siegel & Hartzell, 2003); and art, drama, and creative writing expressive therapy ideas (Selekman, 2005, 2009; Malchiodi, 2003; Bailey, 2000; Wachtel, 1994; Gil, 1994). Clients take the lead in determining their treatment goals, session agendas, who they think should attend sessions, the frequency of visits, and in each session are free to choose from a menu of therapeutic activities that they wish to try between visits.

The collaborative strengths-based brief therapy approach is sensitive to gender power imbalance, cultural, spiritual-wellness, and wider societal social injustice issues that often play a part in the development and continuance of human difficulties. The collaborative strengths-based therapist views the therapeutic encounter as being a political enterprise, particularly with women and clients of color who are marginalized and disempowered in our society. In partnership with clients, the therapist actively collaborates both in and out of sessions with involved and concerned members of their social networks and helping professionals from larger systems. Thus, this ecological family therapy approach targets interventions at the individual, family, social network, larger-systems, and community levels. In this section, I present the major therapeutic components of the collaborative strengths-based brief therapy model as applied to clinical work with children and their families. Case examples are provided.

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Honoring Clients' Stories and Concerns

The renowned philosopher and educator John Dewey believed that any problem that is truly well defined is already half-solved (Parnes, 1992). For

a number of reasons (e.g., managed health care), there is a strong tendency among therapists to try to find the quick solution for their clients' problems without taking the time to determine collaboratively with the clients what the "real" or "right" problem is. Leading proponents of the basic solution-focused brief therapy model argue that therapists do not need to know a great deal about their clients' problems to solve them and that therapists should avoid at all costs engaging in "problem talk" (Berg & de Shazer, 1991) with their clients. However, going with an ill-defined client problem (or goal, for that matter) will make any constructed or selected solution ineffective in the long run. In this light, zeroing in on the right client problem is equivalent to finding the right solution for resolving it. Problems and solutions are close relatives and do not always need to be separated for effective problem solving (Van Gundy, 1988).

Numerous studies have provided empirical support for the key importance of defining the problem properly and precisely in creative problem solving (Csikszentmihalyi & Getzels, 1970; Getzels & Csikszentmihalyi, 1976a, 1976b; Moore, 1985; Hall, 1995; Isenberg, 2009; Roberto, 2009). Doug Hall (1995), a creativity expert and master marketing consultant, found that deferred judgment, or *incubating,* is one of the most important steps in developing creative ideas and high-quality solutions. Csikszentmihalyi and Getzels (1970) investigated the relationship between problem defining and artistic creativity. The artists in their study were instructed to produce a drawing using a variety of objects that had been placed on a table in front of them; a panel of well-known artists and art critics judged the drawings. The results of the study suggested that the artists who approached the task with no set solution in mind and who avoided using predetermined patterns or formulas produced more original and creative drawings than did those who began with a predetermined approach. Interestingly, the most highly rated artists spent considerably more time than the others manipulating the objects on the table. Two important dicta can be extracted from this study that should inform our clinical practices: (1) take the time to determine with the family what it considers to be the "right" problem to begin addressing first, and (2) avoid using a predetermined formula for problem solving.

Frank Gehry, the great modern architect, when offered a new building project, spends a lot of time during the early stage of the design process playing with ideas about the task at hand, doodling and building models of his most intriguing notions to gain as much knowledge as possible about the problem or task. The more he plays with all of these different ideas about the problem or task at hand with his doodles and models, Gehry increases his knowledge about it, and potential solutions to take form, paving the way for a well-constructed and unique final product (Isenberg, 2009).

Families that have been oppressed by their problems for a long time and have experienced multiple treatment failures may feel invalidated and unheard when a therapist fails to give them ample space to share their long,

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problem-saturated stories. According to Anderson (1996), "Understanding too quickly cuts a client's story short and risks eliciting the story that a therapist wants to hear, rather than the story a client wants to tell" (p. 202). Throughout my professional career, I have worked with numerous children and adolescents who had extensive treatment histories and yet were given little opportunity to voice their individual concerns, expectations, and what specifically they wanted to work on changing individually or with their family situations. Fraser (1995) argues that, unless we take the time to elicit from clients and families their attempted solutions and views of the problem, we will have no idea when their problems are really solved, and we run the risk of replicating unsuccessful attempted solutions that have not worked in the past. The case below helps illustrate the importance of both taking the time to collaboratively determine with the family the "right" problem to work on first and making room for their story about the problem situation.

> Ellen, a 10-year-old Caucasian girl, was brought in for therapy by her mother for attention-deficit disorder (ADD), "stealing," "lying," "doing poorly" in school, "fighting" with her siblings, and "breaking" her mother's "rules." According to her mother, Ellen had been sexually molested when she was 6 years old by an uncle. Sensing the mother's strong feelings of hopelessness and despair about being able to help her daughter, I gave her plenty of opportunity to share her problem-saturated story. I also gathered detailed information about her attempted solutions, particularly what past therapists had tried to do with Ellen and her mother that the mother did not find helpful. After receiving ample time to ventilate her frustration about former therapists and the problem situation, the mother became much more receptive to clarifying with me what she perceived as the right problem to work on first. She believed that Ellen engaged in all these objectionable behaviors because of "the trauma" of Ellen's being sexually molested at the age of 6. The stealing behavior in particular began at this time, which was the mother's "greatest source of irritation." The mother agreed with me that it would be too daunting a task to try to change all of Ellen's behaviors at once. For both the mother and Ellen, the right problem to work on changing first was the stealing behavior.

After hearing the mother's frustrations with past therapists and Ellen's chronic behavior problems, it was clear to me that the mother would have felt slighted and would have viewed me as being too much like all the overzealous therapists she had seen in the past if I had moved too quickly to talk about exceptions or prematurely asked the miracle question (which, in essence, is "What would be different if, by a miracle, everything were suddenly okay?"; de Shazer, 1988; see Chapter 2, this volume). By giving the

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mother ample time and space to share her long, problem-saturated story without interruption, I was in a much better place to define the problem to work on first. Future therapy sessions were focused on systematically stabilizing each of Ellen's behavior problems and collaborating with concerned school personnel.

Finally, although pure solution-focused therapists do spend time consolidating clients' treatment gains throughout the treatment process, they also unfortunately tend to steer clients away from sharing concerns that may be unrelated to the primary treatment goal. From a solution-focused purist perspective, this type of extraneous exploration would be considered "problem talk" to be avoided at all costs. *Not* addressing these concerns, however, could lead to clients getting derailed and feeling as though they were back at square one. Therefore, it is crucial that therapists conduct sessions in a balanced manner, where we both amplify and consolidate clients' gains and we *cover the back door* by making room for them to share any concerns or new problems as they arise, addressing these difficulties immediately (Selekman, 2009).

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Doing What Works: Integrating Key Research Findings into Our Practices

Hubble, Duncan, and Miller's (1999) ground-breaking research and therapeutic ideas have enabled therapists to have better outcomes with a wide variety of treatment populations. These researchers took the four common factors found in successful treatment outcome research and developed streamlined questionnaires to measure their presence in a given session in the process of creating a treatment approach that they called *client-directed, outcome-informed therapy.* The four common factors are *the clients' extratherapeutic factors* (clients' strengths, theories of change, treatment preferences and expectations, self-generated pretreatment changes and effective coping strategies, stages of changes, and random events that had benefited them); *the therapeutic relationship* (such relationship skills as empathy, warmth, and validation and such structuring skills as the therapist's timing in the use of interventions, taking charge in sessions, and structuring of sessions as well as overall competence); *expectancy and hope* (how well the therapist conveys with confidence his or her client's ability to change while instilling hope); and *therapeutic models and techniques* (the ability to create a good fit between the therapeutic model and techniques employed and the client's unique characteristics). Interestingly, the variable category that counts the most in terms of successful treatment outcomes is the client's extratherapeutic factors, while the second most important is the therapeutic relationship or alliance. The most surprising finding in close to 50 years of psychotherapy outcome research is the fact that therapists'

beloved treatment models and techniques account for only about 15% of treatment success!

The questionnaires Hubble et al. developed that have been so well validated are called the *Session Rating Scale (SRS)* and *Outcome Rating Scale (ORS)*. The SRS assesses the quality of the therapeutic relationship with the client—that is, whether or not a strong therapeutic alliance has been established—while the ORS solicits feedback from clients throughout the course of treatment on whether they are experiencing change process or not (Miller, Mee-Lee, Plum, & Hubble, 2005). These two important inputs from clients help therapists carefully tailor treatment options to clients' unique needs throughout the course of treatment, which helps prevent premature dropouts from occurring and optimizes the likelihood of positive treatment outcomes. Some therapists and clients feel uncomfortable with or do not like to fill out questionnaires. In those situations, therapists may solicit the same information verbally at each session and make the necessary adjustments based on clients' feedback.

Since the inception of managed health care and owing to reductions in federal and state funding for mental healthcare, there has been a strong push for agencies, mental health clinics, and hospital-based programs for children and adolescents to employ empirically validated individual and family treatment approaches. For a time, solution-focused brief therapy was being highly touted by managed care companies and health maintenance organizations as one of the most strongly endorsed treatment approaches. Many of these companies provided extensive training opportunities in solution-focused brief therapy for both their in-house staff and provider networks. Over time, however, such empirically validated therapy models as cognitive-behavioral therapy (CBT; Weisz, McCarty, & Valeri, 2006; Compton, Burns, Egger, & Robertson, 2002), multisystemic therapy (Henggeler et al., 2009), functional family therapy (Sexton & Alexander, 2005), and brief strategic family therapy (Horigan et al., 2005) came to be more in vogue because they all had strong outcome data to back their efficacy as the treatments of choice for child and adolescent behavioral difficulties. To my knowledge, there have not been any well-controlled experimental research studies with large samples of children that combined both qualitative and quantitative methods with the solution-focused brief therapy model. There are, however, numerous qualitative studies conducted with both the solution-focused brief therapy and, more recently, the collaborative strengths-based brief therapy models where clients rated their treatment experiences very highly (Selekman, 2009; Selekman & Shulem, 2007; Macdonald, 2007; Gingerich & Eisengart, 2000).

The just cited empirically validated family therapy approaches have clearly demonstrated the importance of being integrative, working with subsystems (i.e., allowing separate session time for parents and children), being

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sensitive to child developmental and family life cycle issues, and intervening in the clients' social ecologies (collaborating with involved helping professionals from larger systems and concerned others in their social networks). However, some of the limitations posed to mental health professionals by having to use these empirically validated approaches *exclusively* are (1) having to stay rigidly true to the model with only minimal integration of other insights, (2) having one's own creativity needlessly stifled, and (3) with certain approaches having to be available 24/7, which is highly unrealistic for many therapists. Ethically it is my contention that, as practitioners, we should never permit research considerations to outweigh the unique needs of our clients. Furthermore, one-size-fits-all clinical thinking clearly does not work with every child and family. We need to allow our preferred therapy models to evolve, be flexible and integrative therapists, and look for logical ways to combine the best elements of empirically validated treatment approaches with our own clinical experience and wisdom regarding what works with particular types of child behavioral and family difficulties.

Applying the Multiple Intelligences Model to Family Therapy with Children

I have written in earlier works about the many benefits of utilizing Howard Gardner's *multiple intelligences model* in psychotherapy (Selekman, 2005, 2006, 2009). Gardner (1993, 2004) has identified 10 distinct human intelligences, as follows: *linguistic* (likes to write poetry and creative stories and read), *logical-mathematical* (strong analytical and mathematical skills; likes puzzles, science, computers), *musical* (likes to play an instrument and/or sing), *bodily-kinesthetic* (expresses self best through movement; may like to dance or play sports; likes acting and drama), *visual-spatial* (likes art and photography; strong visualization skills; inventive and has strong sense of imagination), *interpersonal* (strong social skills, natural leadership abilities; likes group projects), *intrapersonal* (introspective; likes journaling about thoughts and feelings), *naturalist* (loves learning about and being out in nature; loves animals, has pets; likes camping), *existential* (searches for the meaning of events and things; curious and reflective), and *spiritual* (may be very religious and believes in a higher power; has learned to believe in him- or herself and have faith during tough times).

The beauty (and special utility) of the multiple intelligences model is that it can aid therapists in matching what they do with clients' particular learning styles and main channels for expressing themselves, thereby capitalizing on their key strength areas and helping to guide the therapeutic experiment construction process. As a nice complement to solution-focused ideas, the multiple intelligences model takes capitalizing on children's and other family members' strengths *to the next level*. The case below illustrates

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how, by capitalizing on a child's key intelligence area, the therapist was able to custom-tailor a therapeutic experiment more precisely to the client.

> Antonio, a 9-year-old from Spain, was having grave difficulty coping with his parents' recent divorce. Since the divorce, he had not seen his father for 8 months. He had been picking on his 7-year-old sister Cecilia, not following his mother's rules, talking to her in a disrespectful way, and engaging in disruptive behaviors in his classroom at school. Lucinda, the mother, openly admitted that she had been yelling at and punishing Antonio quite a bit lately. The family was struggling financially as well. Lucinda had recently lost her job working in a restaurant. She was now cleaning houses in her community to earn some money. One area Antonio excelled at was playing soccer. According to the mother, he was the top scorer in his local community league for children. I really captured Antonio's undivided attention when I invited him to talk about his favorite professional soccer star, the Spanish team, and his best game. The whole room lit up at that point, and he was "all smiles." I learned that his best game of the whole season was when his six goals had won the league championship for his team. He also shared with me that the professional soccer team he really disliked was Barcelona because they seemed to be the champions every year. Learning that Antonio's key intelligence area was *bodily-kinesthetic* and that soccer was his life's passion, I proposed a family soccer ritual for them to experiment with over the next week. The major objective over the next week was for Antonio to see how many "goals" he could score with his mother in 1 week's time. When asked what he would call his team, he said, "My Mother's Team." Lucinda smiled, obviously touched by Antonio's coming up with this team name. The team he was trying to beat and was pitted against was his arch enemy, "Barcelona." Lucinda came up with the scoring criteria. He would score a goal with her by doing any of the following: no phone calls from his teacher about getting in trouble at school; not picking on his sister; and not breaking her house rules and talking to her in a nicer and more respectful way. Whenever he engaged in formerly troublesome behaviors, the Barcelona team would get goal points placed in their column on the chart keeping track of both teams' scores. Antonio did not like the idea of Barcelona beating his team and appeared fired up to lead his team to victory. With the help of Lucinda's supportive coaching and patience, Antonio successfully led "My Mother's Team" to victory over Barcelona. In fact, he set a personal best scoring record—20 goals in 1 week's time! Lucinda was very proud of him and also wanted to let me know that Antonio's sister had also had a few positive "assists" with some of his goals. Lucinda was very proud of Antonio for working

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really hard to turn his behavior around. She also discovered that they needed to play more together as a family. Finally, now Lucinda had a system she could put in place if Antonio began to have difficulties again in the future.

Using Family Art and Play Therapy Techniques

For decades, child and family therapists have vigorously debated which treatment modalities are best suited to children. Child therapists would argue that the child's behavioral and emotional difficulties are caused by faulty parenting, which results in intrapsychic conflicts, developmental arrest, and/or possible psychic deficits. By employing art and play therapy methods, the therapist provides a safe climate for children to play out their conflicts and uses his or her relationship with the child to try to heal the psychic deficits (Kohut, 1971). The parents are typically seen separately or by another therapist. Family therapists would argue that the child's problems should be viewed through a broader lens. The "problem" child's symptoms or dramatic behavioral difficulties may serve a particular function in the family (Haley, 1987; Madanes, 1981) and may be attributable to structural problems in the family (Minuchin, 1974), perpetuated by problem-maintaining parental attempted solutions (Watzlawick et al., 1974), and maintained by constraining beliefs and dominant oppressive stories (White, 2007; Epston, 1998; White & Epston, 1990). Most family therapists would actively involve the parents in the treatment process. Depending on the model being used, the family therapist focuses most of his or her attention on changing parental outmoded beliefs about the child and altering family patterns of interaction that may be maintaining the problems. Some family therapists focus most of their therapeutic attention on changing the parents and spend very little time interacting with the child alone.

It is my contention that both the individual child therapy and the family therapy perspectives offer therapeutic tools and strategies that complement one another—as long as what the therapist chooses to do therapeutically is purposive and accords with both the child's and family's goals. In general, children (and particularly young children) like to play and rarely respond well to talk therapies alone. Sometimes the parents' ways of viewing and interacting with the child change but yet the child remains symptomatic. One therapeutic option in such cases is to use art and play therapy techniques. However, rather than seeing children alone to perform these experiments, I have found it most advantageous to include the parents as both participants and observers in these activities.

Wachtel (1994) and Gil (1994) use a similar format in their clinical work with children and their families. With some cases, it might be a novel experience for both the child and the parents to play with one another or

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to create a family mural or collage together. Family play and art therapy experiments can take the sting out of presenting problems, reduce stress levels, loosen up fixed beliefs about the problem, and alter the family dance in which the problem is embedded. The therapist also gains access to destructive problem interactions and family conflicts which he or she can address directly in a relaxed context in which anything is possible. Sometimes children's art creations can serve as the catalyst for changing and healing their parents. The following case example illustrates this point.

> Sandra, a 6-year-old Caucasian girl, was brought for therapy by her parents, Bill and Evelyn, who were separated after their second marriage to each other. The couple separated after Bill began slapping and pushing Evelyn around when they got into an argument. Both parents were quick to point out their long history of arguing and getting physical with each other.
>
> Sandra lived with her mother and 10-month-old brother, Evan. Despite the parents' difficulties, they were both concerned about Sandra's passivity and wondered whether she was "depressed." Sandra appeared to be very timid and shy. Efforts to engage her went nowhere until I asked her to draw a picture of her family. The parents were quite shocked and even cried when they saw Sandra's drawing. Sandra drew a picture of her family floating in air around the interior of the house; she placed herself outside the front door. She drew very thick lines around the house and had the front door closed.
>
> Seeing this drawing proved to be an eye-opening and emotional experience for the parents. Sandra was also able to talk about how she did not feel "safe" when her parents were together. The child protection and local police departments had a history of involvement with this case and were still involved as a result of domestic disputes. Despite all the chaos in the home, the children were never physically harmed. By the end of the session, the parents were open to working on their problems with anger management, conflict resolution, and violent behavior. We established a no-violence contract as well. I also secured signed consent forms to collaborate with the child protection worker and a local police officer involved with their case.
>
> Through the use of the family portrait drawing, the parents in this case were confronted in a powerful way and began to take responsibility for their problematic behaviors. Sandra's drawing successfully reached a place in the parents' minds that served as the impetus for committing to changing their destructive behaviors. Interestingly enough, the parents disclosed in our session that no therapeutic intervention had ever had more of an "emotional impact" on them than Sandra's family portrait drawing.

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Integrating Narrative Therapy Ideas

Michael White and David Epston's narrative therapy approach is quite compatible theoretically with the solution-focused brief therapy model in several ways. Both approaches share strong Batesonian theoretical influences, are family empowerment models, and capitalize on family members' strengths and resources. The leading proponents of these models believe strongly that children should be advisers when the subject is their own lives (de Shazer & White, 1996). However, since some important elements of narrative therapy are unique to it, I have found it beneficial to integrate them into the basic solution-focused brief therapy model.

Narrative therapists approach cases with a political lens; that is, they bring gender, cultural, and social justice issues into the therapy room. The narrative therapy approach tends to be more meaning-based and historical and makes more room for the family's problem story than does the basic solution-focused brief therapy approach (White, 2007; Epston, 1998; Chang & Phillips, 1993; de Shazer & White, 1996; Jenkins, 1994). By taking the time to elicit the family's story about the problem, narrative therapists can learn a great deal about family beliefs and the various ways family members influence and are influenced by the oppressive problem. With this important information, the narrative therapist can engage in externalizing conversations (White, 1995, 2007; Epston, 1998; White & Epston, 1990) with the family to tease out story lines of competency that can help liberate them from their dominant problem-saturated situation. Externalizing the problem in this way is an effective therapeutic pathway to pursue with families that do not respond well to the basic solution-focused brief therapy approach, have been oppressed by the problem for a long time, have experienced multiple treatment failures, and describe the problem as having a life of its own. Often families that are therapy veterans such as these do not notice times when they are not pushed around by the problem because such events do not fit with their dominant problem-saturated stories. Some therapy veterans may also experience a solution-focused therapist's overemphasis on positive talk as not taking their problem story seriously, being sarcastic, and/or minimizing their plight.

The following case example demonstrates the effectiveness of externalization (White & Epston, 1990) with a 9-year-old African American boy (Jimmy) and his parents, for whom Jimmy's chronic stealing habit of 3 years had become oppressive. I was the fifth therapist the parents had taken Jimmy to see for his stealing problem.

> Jimmy had been stealing money from his parents since he was 6 years of age. According to his father, he also had a long history of using his "slick fingers" to take things from his teachers' desks. Throughout

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the initial family interview, the father called Jimmy's stealing problem "slick fingers." The mother referred to Jimmy as being a "slick thief," able to find their money hidden in shoe boxes and other inconspicuous places around the house.

The use of the miracle question (de Shazer, 1988), coping, and pessimistic sequence questions (Selekman, 2005; Berg & Miller, 1992) proved to be unproductive in the interviewing process; so, I decided to capitalize on the father's externalizing of the problem into "slick fingers." The "slick fingers" construction of the stealing problem was also much more treatable than the parents' other explanations, such as "He must have a character flaw," "We must have spoiled him," and "He is never happy with what he has."

The parents and Jimmy both shared feelings of frustration and hopelessness about ever being able to conquer this problem, with Jimmy readily disclosing that he had "no control" over his stealing problem. By consciously externalizing the problem in our conversation, the parents began to see how they and Jimmy were being victimized by "slick fingers." As a way to help empower the family to win back control of their lives over "slick fingers," I offered them an "honesty test ritual" (Durrant & Coles, 1991; Epston, 1989) to experiment with.

The parents were instructed to leave money out in various locations around the house. After securing a signed consent form from the parents, I contacted Jimmy's teacher to let her know what we were doing to help defeat "slick fingers." The teacher placed previously stolen items on top of her desk for 1 week to test Jimmy's ability to stand up to "slick fingers" and not allow that urge to push him around. I emphasized to the parents, Jimmy, and the teacher the importance of this being a team effort. I also pointed out that stealing habits do not die easily.

One week later, the family came back in good spirits, reporting a perfect week. Jimmy openly admitted that on two occasions he almost succumbed to "slick fingers'" attempts to brainwash him to steal, but he fought back with useful self-talk. The parents also admitted that they had some moments of distrust with Jimmy but avoided the temptation to confront him. The teacher had reported to the parents that there were no signs that "slick fingers" had gotten the best of Jimmy in 1 week's time.

Since the honesty test strategy proved to be so successful, I continued to use it throughout the course of family therapy. I ended up seeing the family four more times. In our final session together, I threw a party for Jimmy and his parents to celebrate their victory over "slick fingers." The teacher joined the festivities as well.

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One of the most compelling features of White and Epston's (1990) narrative approach is the use of an "audience" of friends, relatives, and significant others in the identified child client's life to bear witness to his or her competencies and to pioneer a new direction within the family and in other social contexts. The telling and retelling of the child's new evolving story of competency is empowering and can create possibilities (White, 1995, 2007; Epston, 1998; de Shazer & White, 1996). The therapist also is decentralizing him- or herself within the life of the family by having key members of the clients' social network serve as their main support structure for staying on track and accentuating their progress.

White and his colleagues have developed several effective therapeutic rituals that can empower families to gain their freedom from the problem's reign over them (White, 2007; Epston, 1989, 1998; Durrant & Coles, 1991; White & Epston, 1990). One quite effective ritual with children's behavioral problems is the *habit control ritual.* Using this therapeutic ritual, family members keep track of their victories over the problem and the problem's victories over them on a daily basis. The therapist can raise dilemmas with family members around their need to be a unified team rather than caving in to having arguments about the best course of action for defeating the problem or continuing to blame the identified child client for their difficulties. I typically instruct families to work out together in order to be as fit as possible to do battle with the tyrannical problem. Once the family has defeated the problem, we can celebrate the change process by giving the family a party, certificates, ribbons, or trophies (Epston, 1989, 1998; Durrant & Coles, 1991; White & Epston, 1990). Celebrating change with families in this manner nicely complements the positive-oriented basic solution-focused brief therapy approach and is an effective way to further amplify "news of a difference" for them.

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Quieting the Mind: Teaching Children How to Achieve Inner Peace with Mindfulness Meditation and Related Practices

One valuable life skill and coping strategy we can teach children as young as 6 years old is *mindfulness meditation* (Selekman, 2005, 2009; Lantieri & Goleman, 2008; Thomas, 2003; Hanh, 2003, 2007). Growing up in a world of extremes and high levels of stress, children can greatly benefit from learning how to wind down from all of the media and high-tech stimulation they are bombarded with daily by quieting their minds and deliberately focusing on their internal core and well-being. Thomas (2003) calls this quiet time "heart and soul time" and believes that parents should establish as a daily ritual a specific time for children to meditate.

When introducing mindfulness meditation to children, I present it in a very concrete way by having them experiment with such simple activi-

ties as carefully watching how they breathe by focusing their attention on their chests expanding and contracting, paying close attention to every step they take while walking, or listening carefully with their eyes closed to sounds they hear around themselves, simply labeling each sound they hear to themselves. Another mindfulness practice I have children do is *cloud-shape watching* (Selekman, 2009). This activity entails going outside and while looking up at the clouds trying to identify familiar-looking shapes of animals, human heads, and other recognizable objects. Not only is this a fun activity to do, but also it can become like a game for children in that each time they go out and cloud-watch they can try to identify new recognizable animals, human heads, and other familiar objects. I have them bring in their written-down cloud-shape discoveries to talk about. Parents can encourage their children to go outside and cloud-watch when they are being pushed around by negative thoughts and feelings, which can help disrupt the inner turmoil they are experiencing in their heads.

Many psychological and physical health benefits accrue to children who engage in daily mindfulness meditation. Psychologically such practices help them to temper their wild stallion thoughts and feelings and also to enhance their concentration and problem-solving abilities. Physically, we know that mindfulness meditation lowers our breathing and heart rates and strengthens our immune system (Selekman, 2009; Lantieri & Goleman, 2008).

Integrating Contributions from Winnicott, Siegel, and Other Developmental Theorists

In reviewing the solution-focused brief therapy literature, we see little mention of the importance of developmental theory in informing what we do clinically with children and their families. Having a good grasp of developmental theory can aid us in determining how best to communicate with the child and in designing and selecting therapeutic experiments that he or she is capable of understanding and performing. According to the brilliant child psychiatrist D. W. Winnicott, “One must have in one’s bones a theory of the emotional development of the child and the relationship of the child to the environmental factors” (1971b, p. 3). For the remainder of this section, I discuss important contributions from Winnicott, as well as from other interpersonal neurobiological or related developmental theorists that therapists should consider in their clinical work with children and their families. Winnicott (1971b) always took into account the strengths and resources of the child as well as the parents’ availability and capability to facilitate the child’s maturational process. He believed that clients want to be co-collaborators and inevitably guide therapists toward what they really need. When stuck with a case, Winnicott knew how to tolerate and make clinical use of the “not knowing.” He had “the capacity to tolerate feeling ignorant

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or incompetent and a willingness to wait until something genuinely relevant and meaningful emerged" (Casement, 1985, p. 9).

Winnicott (1971b) attempted to create what he called a "holding environment" in which children believe they will get help for their difficulties. He would try to create a natural and free-flowing human relationship in which clients surprise themselves by sharing important thoughts and feelings (Casement, 1985). Winnicott (1985) believed that some clients' difficulties arise simply because no one has ever "intelligently listened" to their story. Finally, Winnicott practiced somewhat like a brief therapist by increasing the time intervals between sessions once progress occurred. One of Winnicott's (1971a) most famous play therapy techniques was the Squiggle Game. He would say to the child:

> "Let's play something. I know what I would like to play and I'll show you. This game that I like playing has no rules. I just take my pencil and go like that . . . (do squiggle blind). You show me if that looks like anything to you or if you can make it into anything, and afterwards you do the same for me and I will see if I can make something of yours." (pp. 62–63)

Not only does the Squiggle Game help build rapport with the child, but also it furnishes the therapist with valuable information about the child's inner world and provides opportunities to indirectly offer children new ideas or solutions to their difficulties. Winnicott believed strongly that therapists working with children had to be able to play and could enjoy playing.

In expanding on Winnicott's Squiggle Game technique, I like to include the parents in the process. I may have the parents draw a squiggle and have the child construct a picture out of the squiggle and tell a story about their picture. The child then draws a squiggle, and the parents follow the same procedure (see Chapter 5). Gil (1994) has developed another version of the Winnicott Squiggle Game in her clinical work with abused children.

Dan Siegel (Siegel, 2007; Siegel & Hartzell, 2003), one of the leading pioneers in the growing field of *interpersonal neurobiology,* has demonstrated in his research that our brains are socially oriented organs and the kinds of mental interactions that children have with their parents shape their capacity for developing empathy for others. He believes that when children consistently sense being "emotionally felt" by their parents and have strong connections with them, they develop *mindsight.* Mindsight is the capacity to perceive our own thoughts, feelings, perceptions, sensations, memories, beliefs, attitudes, and intentions—*and those of others.* Children master this ability through their parents regularly sharing their own thoughts, feelings, and memories with them. Through these kinds of meaningful interactions

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with their parents, children gain self-understanding and build social skills (Siegel & Hartzell, 2003).

Another important concept that has grown out of both Siegel's and attachment theorists' research (Ainsworth, 1978; Bowlby, 1979, 1988) is *narrative coherence*, which is one's ability to access and make sense of one's personal life story. Narrative coherence paves the way for an individual's ability to establish and maintain solid interpersonal connections with others. In my clinical practice with children, I regularly invite parents to share their personal stories of growing up—their struggles and the high points, what their relationships were like with their parents, and what their grandparents were like as people, including valuable words of wisdom and life experiences they shared with them. Parental storytelling strengthens their relationships with their children and helps them to trace and make sense of their roots and heritage.

Historically, there has been a heated debate across all mental health disciplines whether "nature" or "nurture" is responsible for childhood problems and personality development. Greenspan (1995) argues that we should instead look at how nature and nurture work in tandem. Using the metaphor of a lock and key to describe the unique and continuous interplay between nature and nurture, Greenspan says:

> The child brings his "nature" and the parents bring warmth and love wrapped up in a particular pattern of caring. This interplay operates like a lock and key. Finding the right key creates new patterns of interactions. Each stage of child development has its own goals, which are in turn associated with new ways for nature and nurture to work together. For each stage of development, there is a special "key." With the right knowledge about how to find the "keys," parents can learn how to greatly influence this interplay of nature and nurture in their children. (p. 7)

Therapists who treat children need to be knowledgeable about child development. By educating parents on what to expect developmentally of their children and helping them find the right "keys," or courses of action, for supporting their children's mastery of developmental tasks, we can have a much more meaningful impact on families. Through the use of education and normalization, therapists can dispel parental concerns about what they and referring persons may be identifying as "pathological" behaviors. In reality, such behaviors often turn out to be the child's struggle with particular developmental tasks. As Achenbach (1990) stated:

> Many behavioral/emotional problems for which professional help is sought are not qualitatively different from those most individuals display to some degree at some time in their lives. Instead, many problems for which help is sought are quantitative variations and characteristics that

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> may normally be evident at other developmental periods, in less intense degree, in fewer situations or in ways that do not impair developmental progress. (p. 4)

From a Piagetian cognitive-developmental perspective, Cowan (1978) contends that children's problems, struggles, and conflicts are necessary and inevitable for their growth. At each developmental stage, children have to confront and negotiate personal and environmental mismatches (i.e., the complex interactions between their psychological functioning at a given stage with situational demands and the values of their families, peers, schools, and communities) in order to minimize the extent of the mismatch. This can lead to *disequilibrations* and new problems. In our clinical work with children and their families, we need to encourage parents to be supportive of their child's attempts to cope with these disequilibration periods during their development.

Another important developmental area that therapists should be sensitive to are children's *temperaments*. Each child brings into the world this unique innate part of him- or herself (Kagan, 1994). Often when parents do not match up their responses well with their children's unique temperaments, such as becoming inflexible and too emotionally reactive, they end up clashing with and frustrating one another or feeling misunderstood. Taffel (2009) recommends that parents first try to identify their children's unique temperaments and determine what types of responses from them seem to fit best when the children are emotionally distressed. For example, a "clingy child" may need more one-on-one time with a parent prior to each transition (say, at bedtime) or a strong-willed child may need to be offered two options instead of one (both acceptable to the parents).

For numerous reasons, most family therapists do not use developmental theory to guide their assessment observations and to design appropriate therapeutic experiments. When training and consulting with family therapists, I frequently hear the criticism that one's thinking in developmental terms about a particular family member or the identified child client is "too linear" or "not systemic." The child client is not some innocent victim in his or her family drama but, instead, plays an active part in contributing to family stress and difficulties. The child's role in the family drama can be determined by directly observing family interactions in therapy sessions and may be graphically depicted in the child's art and play activities. We need to be sensitive to the effects of the child's own adaptation to his or her developmental struggles on other family members and how family members, in turn, respond to the child. For example, if parents provide a great deal of assistance to help their child master toilet training, they may enable the child to achieve competence quickly; however, such a "solution" may fail in the long run because the child may lack the self-confidence to use the potty

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alone. The rewards of independence and confidence go to the child who is allowed to try and fail, struggle, and then finally succeed. Lastly, we also need to examine and explore how family life cycle issues affect the child's functioning (Carter & McGoldrick, 1988; Haley, 1986).

Flying Out of the Center: The Art of Therapeutic Improvisation

Jazz critic Robert Levin (1987), in describing the creative, even brilliant, improvisational abilities of the late saxophonist and reedman Eric Dolphy and other pioneers of the avant-garde jazz movement, rhapsodized that "the new jazz is about learning to fly, to fly out of the center. . . . To fly means to end the pursuit of the original, the given, the order, to break that circle, and to pursue instead the rediscovery of surprise—which is to say the rediscovery of reality and the vital."

Levin's sentiment captures the essence of how we as therapists can help liberate the families with which we work from their oppressive problem-saturated life stories. Through the use of humor—even to the point of absurdity now and then—and surprises in the therapeutic process, we can move our clients out of the center, bring back lost spontaneity and playfulness, and alter fixed beliefs and entrenched family interactive patterns that keep them stuck. Similar to what chaos theorists refer to as *fractals*—that is, unique patterns left behind by unpredictable movements (Briggs, 1992) that occur in nature—I want to inject humor and surprises into each family session to help introduce novel ways for family members to look at their original problem-saturated situations. To fly out of the center and be effective improvisors, we have to feel free to step out of our comfort zones and allow our creativity to run wild! When flying out of the center with a family, a therapist can tell jokes, explicate or exaggerate a family pattern in a humorous way, share anecdotes and stories, use metaphors, and be as unpredictable as possible. The therapeutic experience with children and their families should be a fun, surprising, and at times wacky adventure. Two case examples of flying out of the center offer possibilities.

> Alison, a 6-year-old Caucasian girl, was brought into therapy for "low self-esteem," "isolating herself from the rest of the family," and looking "depressed." Alison came to the session with her parents. Her 13- and 16-year-old sisters were involved in school-related sporting events, so they did not attend our first family session. No precipitant was identified for Alison's symptoms. Earlier in the session, I felt that I had joined well with the parents but failed to connect with Alison. Alison would not say a word to me, even after I asked the imaginary magic wand question, which is not unlike the miracle question, except with a wand and tried to engage her in a board game on the floor. It appeared that

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my approach with Alison was too straightforward, and what I really needed to do was something funny and unpredictable. I decided to fake crying and say in a sad childlike way, "I'm telling my mommy that Alison won't play with me" (I put a super sad look on my face). Suddenly, Alison began to smile and laugh at me. She then got on the floor and asked me to play a board game with *her*! By the end of the session, Alison opened up about what was making her so sad. Apparently, she had recently stopped getting the kind of attention she was used to getting from her dad because of his new involvement in coaching her sisters' softball teams. Hearing Alison's concerns proved to be a newsworthy experience for the parents, and the father promised that he would set aside more individual quality time to spend with Alison.

There are many popular children's stories written both in this country and abroad whose main characters, themes, and story lines parallel our young clients' stories. As another way of engaging a child, improvising, and introducing new angles on the child's story, I sometimes share with the child and his or her family a story that seems to fit their situation.

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Walter, an 8-year-old Caucasian boy, was brought for therapy shortly after his father, Curtis, had gotten custody of him. Walter and his mother, Michele, had a strained relationship, and she no longer wanted custody. Following the parents' divorce, it had been decided in court that Walter would go live with Michele. According to Curtis, while Walter lived with his mother, she would "yell at him a lot," "neglect his needs," and "favor Monica," his 10-year-old sister, who also lived with Michele. It was Curtis's hope that Walter would use counseling to get out all of his "bad feelings" about his "awful experiences" living with Michele. Walter looked sad when I first saw him in the waiting room.

When I greeted the family in the waiting room, I observed that Walter was reading Dr. Seuss's *The Cat in the Hat Comes Back*. Thus, in thinking about the pervasive theme in Walter's story of being an "invisible" child when living with his mother, I decided to share the book *Moomin's Invisible Friend* (Jansson, 1962) with Walter and Curtis. The story in many ways paralleled Walter's. Moomin, the main character, and a friend, Too Ticky, one day brought home a new friend, Ninny, for Moomin's parents and friends to meet. However, nobody could see Ninny because she was invisible. Ninny was being raised by her nasty aunt, who was so horrible to Ninny that Ninny became invisible. Moomin's parents and friends were the nicest people in the Moomin Valley. On a daily basis, Moomin, her parents, and the former's friends would treat Ninny very nicely and compliment her. With almost every act of kindness and compliment, a different part of Ninny's

> body would appear. After some time had passed, most of Ninny's body could be seen except for her head. Moomin's family decided one day to take Ninny to the sea to relax and swim. Moomin's mama was standing on the edge of a rock hesitant to jump in, for the water was very cold. Moomin's papa decided to push his wife into the water. As he snuck up behind her, Ninny thought this was wrong and bit his tail to stop him. While Moomin's papa was screaming in pain, Ninny's head suddenly appeared. Everyone jumped for joy! Finally they could see all of her! Ninny was really happy too because she was no longer invisible. Moomin urged Ninny never to make herself invisible again. Ninny promised, "Never! Oh, never!"

After hearing this story, Curtis vowed that he would not allow his son ever to become invisible while living with him. Walter liked the story a great deal and said he could identify with Ninny. We used this story as a vehicle for discussing his thoughts and feelings about when he lived with his mother. Over time, Walter's view of himself changed as well as his pessimistic outlook on the future. His father was highly invested in building a nurturing relationship with Walter.

To conclude this discussion on flying out of the center—outside the comfort zone—with children and their families, let me share this thought from the pioneer humanistic psychologist James Bugental: "The seasoned therapist is able to 'work on the edge of awareness' and is a true artist rather than a technician. True art is only to be found on the edge of what is known—a dangerous place to be, an exciting place to work, a continually unsettling place to live subjectively" (Bugental, 1987, p. 95).

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Using Postmodern Therapy Ideas

According to Fruggeri (1992), therapists who consider themselves to be postmodern practitioners should acknowledge their premises, points of view, and biases with their clients. She argues: "It is through this acknowledgment that they [therapists] can observe their own way of constructing the phenomena they are observing and their relationship to them" (p. 50). Postmodern therapists avoid adopting a privileged expert position with their clients by trying not to present them with some "higher truths" or final explanations about their problem situations. Alternative constructions of the client's problem situation and therapeutic tasks are presented in a tentative way: "I wonder if ... " "Could it be ... ?" "This task may be useful as an experiment. ... " Postmodern therapists recognize that there are a multiplicity of views for any given client problem situation, with all views constantly in flux (Hoffman, 1990, 2002).

Family problems are viewed as being an "ecology of ideas" (Bogdan,

1984). Often parents get the idea that their child may have a *problem* from people outside their immediate and extended families, such as an adult friend, the pediatrician, a school principal or teacher, or even a popular talk show host. Operating from this postmodern perspective, the main role of the therapist is to facilitate the renegotiation of the meaning system within which "the problem" exists. Thus, the therapist actively enters into dialogue with those individuals who maintain the problem definition and becomes a collaborator in the construction of new client narratives (Anderson, 1997; Anderson & Goolishian, 1988b; Spence, 1982; Schafer, 1994). The family can be invited to share with the therapist which involved helping professionals are part of the problem system and with whom the therapist should collaborate. I view these helping professionals as potential allies that can serve as key members of the *solution-determined system*—that is, offering us creative input in the solution construction process (Selekman, 2009).

In a fascinating postmodern study of expert practitioners from a variety of professional disciplines, including therapists, Schon (1983) discovered that these practitioners utilized two processes when managing work tasks: *reflection-in-action* and *reflection-on-action*. He found that the critical reflective thinking that the practitioners employed in their work was an artistic process, not purely a cognitive process of analysis and speculation. For Schon, reflection-in-action is the capacity to keep alert, listen intently, and improvise in the midst of action that does not require the practitioner to stop and think. Reflection-on-action consists of asking oneself questions about action already undertaken from a critical perspective.

In a therapy context, reflection-on-action entails thinking about one's motivations for behaving in a particular way in a session (questions asked and/or interventions tried) and what aspects of the client's story one has taken most seriously (problem-saturated beliefs or solution talk). With reflection-on-action, a therapist seeks new ways of approaching a client's problem situation in a future therapy session, accepts the possibility that it may not fit into any pattern of understanding in the therapist's present repertoire, or accepts that he or she has tried to make it conform to a particular theoretical orientation. When we find techniques that are unusually effective with particular clients, in similar cases the memory of that response jumps to the forefront of our minds and we try out the same techniques again to see if they will work. If they do, the initial registration or "logging" of their success in our memory is reaffirmed, and the same set of techniques may well become a tried and trusted response to situations characterized by similar patterns. In other words, it becomes a theory in use (Brookfield, 1987; Schon, 1983).

One famous reflective practitioner was the great physicist Niels Bohr. Bohr was never fond of axiomatic systems and declared repeatedly, "Every-

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thing I say must be understood not as an affirmation but as a question" (in Capra, 1988, p. 18). In a similar vein, psychology researcher and critic Robin M. Dawes (1994) argues, "Responsible practitioners should practice with a cautious, open and questioning attitude" (p. 31). Through the use of reflection-in-action and reflection-on-action, we can become better improvisers, be more critical of our therapeutic assumptions and interventions, and be more therapeutically flexible.

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