A Child Psychotherapy Primer

Potential Problems

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From *A Child Psychotherapy Primer* Josiah B. Dodds Ph.D.

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POTENTIAL PROBLEMS

WHAT LIMITS ON THE CHILD'S BEHAVIOR DO YOU SET AND HOW CAN THEY BE ENFORCED?

The first task of the psychotherapist is to establish rapport with the client. Many beginning child psychotherapists are reluctant to set and firmly enforce limits on their client's behavior in the therapy room for fear that the child will not like them. An extreme example of this happened to a colleague in training with me. His 11-year-old client proceeded to attack a wall in the playroom with his hunting knife. The therapist simply watched during the hour as the child destroyed the wall with more and more frantic behavior. The child never returned to the clinic, and the speculation was that the boy became overwhelmed and thoroughly frightened by his own impulses. He needed help in controlling himself, not catharsis. In the long run and in the short run, it helps the child feel more secure when the therapist sets and enforces limits on behavior.

The therapist can make the job of rule enforcement easier if the therapy room is set up with minimum potential for destructive behavior. For example, if there are no darts with points, then a whole set of safety rules need not be established. Similarly, the therapist might wish to ask him/herself if it is necessary to have missile-shooting toys (guns), hard balls, exposed fluorescent lights, reachable microphones, and other hazards in the room. However, no room can be totally breakproof and no therapist hitproof, so the therapist must be prepared to set and enforce limits.

Usually it is best not to explain the rules limiting the child's behavior until the occasion arises. If the child threatens with words or, more often, with actions to hurt him/herself or the therapist or to break up the room or toys, then you might say something like, "You know, we don't have many rules in here, but there are three general rules: you can't hurt yourself, you can't hurt me, and you can't tear up the room."

In thinking about setting and enforcing limits the tendency is to think in terms of aggressive behavior. There are of course other behaviors that might require limitation by the therapist. Would you, for example, allow the child to disrobe, to urinate or defecate on the floor (which is certainly not without its aggressive features), run water on the floor, pour all the sand out the window, smear clay on the

carpet or walls, masturbate, or take toys home from the therapy room? For any given child there might be a therapeutic reason not to limit one of these behaviors, but generally, it seems to me, the child would not be helped to adapt to our social world if he/she were allowed free rein of behaviors that flagrantly violate basic social convention.

Whatever limits the therapist sets, it is more effective if they are enforced firmly, consistently, and unemotionally. The therapist who gets into a personal power struggle with a child client ought to examine his/her reasons why this is happening and even explore the question of whether child psychotherapy is the proper business to be in. Winning a power struggle for the therapist's personal reasons has no place in child psychotherapy.

HOW DO YOU DEAL WITH THE CHILD'S AGGRESSIVE BEHAVIORS?

Explaining the reason behind a limit may be helpful to the child. It should be easy for even the young child in therapy to understand that destroying the room and/or toys means that they will not be available for other children or for the same child next time. Not hurting self or others is a bit more difficult to explain on logical grounds that the child can understand. "It just isn't done" may be the level at which the therapist will have to leave it if the child asks why. In any case, beyond explaining the limit, the wise therapist is not pulled into an argument with the child.

The actual enforcing of the rules can be done in graduated steps: give the child a reminder of the rule, command the child to stop, physically restrain the child. The therapist holding the young child during a tantrum might repeat several times in a voice more calm than the therapist invariably feels, "I simply will not let you hurt yourself [me, the room]." It may be impossible to restrain physically an older child who is a good match for the therapist's strength and speed. The absolute last means the therapist has of enforcing a rule is exclusion from the therapy room, the clinic, and treatment. In 20 years of child therapy I have not had to go to that extreme.

In order to help the beginning therapist think about possible responses he/she might make in an actual therapy situation, the following cases are given. What would you do and say in each of these instances?

Episode 1

Frank, 4 ½ years old, has problems Erikson would describe as a struggle of wills: his will against others and his will against his own impulses. In this twenty-fifth session he is painting at the easel when he stops and with a mischievous grin says to the therapist, "You know, I could take this brush and paint and throw it all over you and the ceiling."

THERAPIST:

Episode 2

Debbie, 8 years old, an only child, is defiant and verbally abusive to parents, teachers, and other adults. She bullies smaller children. Near the end of the fifth session:

DEBBIE: "I'm going to take this doll home [small 4" mother doll].''

THERAPIST: "I know you would like to take the doll home, but there is a rule here that toys can't be taken out of the play room."

DEBBIE: "I don't care, I'm going to take it!" (She grips it tightly in hand and heads for the door.)

THERAPIST:

Episode 3

Bill, a large, husky 11-year-old, was referred for school failure and fighting with peers. Weekly therapy sessions have taken place over the past 10 weeks. The rules "you can't hurt yourself, you can't hurt me, and you can't tear up the room" had been explained early in the first session, because his rambunctious behavior in the first session threatened to violate the latter two rules. Nevertheless, he proceeded *each* session to break the limit once, usually by slugging the therapist in the arm or stomping on his foot. At session 11, Bill strides into the play room and swings the heavy punching bag, which hangs from the ceiling, into the head of the therapist. The therapist does and says the following:

THERAPIST:

For more extended and excellent writings on dealing with aggression I urge you to read the articles by Ray Bixler (1964), Haim Ginott (1964), and Allen (1942), chapter 7, "Problems Arising in Working With Aggressive Behavior," pp. 203-241.

WHAT SHOULD YOU DO ABOUT PHYSICALLY AFFECTIONATE BEHAVIOR?

All models of child psychotherapy, I believe, would suggest that the therapist accept the child's affectionate behavior and the feeling behind it. Even when the child is using the affectionate approach not so much as an expression of genuinely felt affection but as a maneuver in some kind of power struggle with the therapist, the therapist would accept the overture at face value, recognize the ploy, and then help the child work out the control issue more overtly. Most therapists would not argue with the child by saying, "No, you don't like me, you are just saying that to get your own way," because the child, in addition to using the statement as a manipulation, may indeed like the therapist. A more productive response from the therapist might be, "Well, that's nice. I like you too." Then the therapist waits for the next move by the child. If it is a request from the child that is refused by the therapist, and the child says, "Why can't I? You don't really like me." The therapist can say, "Sure I do; that has nothing to do with your wanting to take that car home with you."

Assuming that the affectionate overture from the child is an expression of a genuine feeling of liking the therapist at that moment, the flip side of the feeling is wanting to be liked, to have the affection reciprocated. Child therapists of all theoretical persuasions would respond with some form of acceptance that conveys respect and caring for the child. Therapists would differ, however, on how active they would be in expressing direct affection. Personally, I could not remain the neutral, accepting, noncommittal therapist called for by Axline and Moustakas; I would actively reciprocate and express my affection for the child on the assumption that when the child expresses affection, he/she is also making an inquiry about my love toward him/her. This presents a good opportunity to communicate a feeling of positive regard for the child. (If the therapist does not, in fact, like the child, he/she has no business seeing that child in therapy.)

Probably most child therapists would agree that reciprocating negative emotions (e.g., anger,

jealousy, and disgust) directly is not generally therapeutic. The argument might be made that just as one should not reciprocate negative emotions, one also should not reciprocate positive emotions; one should be consistent. I do not buy that argument because of the different nature of positive and negative emotions. The positive emotions of acceptance, regard, and love are central to the person's existential core; one must give and receive these emotions from early infancy to build basic trust in the world and to feel OK about oneself. It is often these very experiences of acceptance and love from others that the children in psychotherapy are lacking. In psychotherapy they receive some measure, preferably a full measure, of love and acceptance from the therapist. An emotion like anger, on the other hand, is less central to the person's being than is love. A person is angry at another because of what that other does or does not do to or for the person. The angry person does not generally reject the other as a person or else he/she would not bother getting angry with that person. For an excellent discussion of the degree of centrality of these emotions in the life space see Hanna Colm, "A Field-Theory Approach to Transference and Its Particular Application to Children," in Haworth (1964).

When the child makes affectionate overtures to the therapist, the therapist, after responding in appropriate kind, will be able to make better use of the exchange if he/she understands what underlies the overture. Is it manipulation? Is it display of affection to a transference object? Is it a spontaneous expression of a feeling? Is it a move seeking acceptance and affection from the therapist? Is it some combination of the above motives? The understanding of the child's motives will help the therapist know the child better and know what the therapist's *second* move should be.

The erotic components of affectionate feelings and behavior may present problems. Children communicate more easily and more often than do adults through physical means: touching, cuddling, hitting, spitting. Society spends enormous energy teaching the child to shift from physical to verbal means of communicating feeling. (Then the adult goes to a sensitivity group to learn how to touch again!) Probably the reason we socialize children to stop touching is because of our hang-up with sex. There are, however, some real problems. Holding a 6-year-old who crawls onto your lap in therapy is different from holding a 16-year-old of whatever sex on your lap. At what age does one draw the line? Just as a rule of thumb, when it begins tingling, be alert and disengage. Also, if the therapist notices the child getting sexually turned on, the therapist should cool it. There are two reasons for this move: (a) pedophilia is taboo and illegal and (b) the child (or adult) client should not have sexual needs met in the therapeutic

relationship because therapy is a laboratory of life, not the real thing. Furthermore, a "mutual" erotic involvement between client and therapist, whatever the age, is inevitably not mutual. The therapist, through his/her power position, is usually taking advantage of the client to meet the therapist's needs, whether the involvement meets the client's needs or not.

One final note on physical means of expressing affection. Some children have already learned at an early age that touching is bad, and they feel that being touched intrudes on their privacy. The therapist must respect the child's discomfort with physical contact. If the therapist blasts through the child's comfort level in the belief that physical contact is natural and healthy, then he/she shows the child a lack of respect and acceptance, without which therapy cannot progress successfully.

WHAT CAN YOU DO WITH A BOSSY CHILD?

"No! Put that there." "Don't talk." "Give me that truck." "Raise your hand." "Make her drive the car here." Every child therapist sooner or later receives these commands. What do you do with the child, and what do you do with your own feelings?

To deal most effectively with the bossy child, the therapist needs to understand why the child is bossy. Is the child simply imitating a bossy person in his/her life? Is the child annoyed with the therapist's intrusiveness and trying to put a stop to it? Is the child attempting to counter feelings of inadequacy and impotence by controlling his/her environment, including the therapist? You can begin to test some of these hypotheses by going along with the child's directions to see how persistent the behavior is. If it goes on for some time, you might resist a bit, perhaps by ignoring the commands, to see how adamant or upset the child becomes. You might even try asking the child why he/she is giving orders. You could wonder out loud if he/she is bossed around a great deal. Even if you do not get the reason, you will get some idea about how aware the child is of his/her behavior or at least how willing the child is to admit the behavior.

After you have some idea about why the child is bossing you around, then how you respond will depend on your therapy goals. If you are trying to foster awareness in the child of his/her own behavior, you might simply comment on the fact that the child is giving a great number of orders. If you are

attempting to foster awareness and acceptance of feelings in the child, you might make comments about how good it feels to be in control and boss people around (if that is indeed your understanding of what underlies the child's bossy behavior). If your goal is to help the child develop more adaptive social skills, you might comment on how most people do not like to be bossed around and that this behavior can lose the child some friends. You might drive this point home by becoming exaggeratedly bossy with the child yourself for just a few moments.

Since most people do not like to be bossed around, you will undoubtedly be annoyed with the child who does this to you. What you do with these feelings depends again on your therapy goals and techniques and also on the strength of these feelings. You might not say anything about your feelings if the goal is to help the child recognize his/her own feelings. If your goal is developing social skills, it would probably be helpful for the child to hear how bossy behavior makes people feel. If you do tell the child how you feel, it could be interpreted by the child as a hostile, critical remark. It is tricky to convince a child that you like him/her but you do not like his/her behavior. Nevertheless, you may be pushed beyond your tolerance level for being bossed. You may simply state that you are going to stop obeying the child's commands because you do not care to be ordered around. If you have a solid relationship with the child, it should survive that. At the very least this will let the child know you are human.

WHAT CAN YOU DO ABOUT THE CHILD WHO WANTS TO END THE SESSION EARLY?

As with any single behavior, a child's leaving a therapy session early could have any one of a number of causes. So the therapist's first job is to understand why the child is leaving early, then base the response to that behavior on the underlying reason. The following are some possible reasons:

1. The child is angry at the therapist and thinks or says, "I'm mad at you and I'm not going to play with you anymore."
2. The child doesn't want to clean up the room at the end of the session.
3. The child fears making the parent, who is transporting the child home, angry because of the long wait.
4. The child is bored.

5. The child has questions about his/her relationship with the therapist and wonders if the therapist will chase him/her, will insist on his/her staying, will become angry, will care enough to react at all.

6. The child is testing the limits, is curious as to the therapist's reaction to transgressions.

7. The child is starting to be afraid of becoming too close to or too dependent on the therapist.

8. The child is frightened about uncovering painful emotional material.

9. The child has to go to the bathroom.

10. The child is reacting to separation and wants control of it, "You can't leave me, I'm leaving you."

11. The child is looking forward to an exciting activity that follows the therapy hour (e.g., a party or a visit to the dentist).

12. The child is hungry or thirsty.

13. The child is getting sick.

14. The child wants to show the parent something.

When the child leaves early, the therapist might ask, as the child threatens to go or actually goes out the door, why he/she is leaving. The child may not be able or willing to say, but it seems the simplest way to start. I would follow the child in order to rule out external reasons like toilet needs or fear of keeping the transporting parent waiting. If the reason is not evident, I might say something like, "Well, I won't stop you from ending the hour, but I wish you wouldn't. I'll be in our room until our hour is over if you want to return; in any case I'll see you next time." If I am worried about a young or irresponsible child's safety, e.g., in wandering away from the clinic, I would keep a surreptitious eye on the child.

Then comes the tough part—trying to determine the cause(s) for the child's early departure. The therapist might approach the problem by reviewing the content of the hour, especially what was going on just prior to the child's leaving. Whatever the result of that effort at understanding the underlying causes, the reason will undoubtedly come up again, either it will be brought up by the therapist or, if it is important to the child, the child will continue trying to get that message through to the therapist.

WHAT DO YOU DO WHEN THE CHILD WANTS TO PROLONG THE TIME OF THE SESSION?

When a child delays leaving at the end of a session, either the child likes what is happening in the room with the therapist or there is something aversive outside following the session, or both. In my experience the reason has most often been the former. As with other behavior, the therapist needs to understand the child's motives in order to best help the child deal with the conflict between his/her desires and the realities of the world. Even without complete understanding of the child's motives, however, the therapist might say something like, "I know you don't want to go; I enjoy our time together too, but our time is up and I have to go. I'll see you next week." The therapist then puts the material away and heads for the door saying, "Come on." If the child still refuses to leave, the therapist just goes out the door and walks (slowly) to the waiting room to inform the parent of the situation. On occasions where the child goes home alone from the clinic, I have simply gone into a colleague's office and shut the door. (Then my colleague has to figure out a way to get me to leave.)

In general, I try to convey to the child in this situation an acceptance of the child's feelings about wishing to prolong the time and make an objective presentation of reality to the child through nonemotional actions that communicate a nonnegotiable position.

WHY DO CHILDREN STEAL ITEMS FROM THE THERAPY R OOM AND WHAT CAN YOU DO ABOUT IT?

The behavior of taking something from the playroom can have very different meanings for different children. The lay person generally views stealing as a crime and one who steals as a criminal; therefore, children who steal are budding criminals and have a serious defect in their moral character. It is difficult for me to believe that a child who takes a toy from the therapy room is a young psychopath, although that is perhaps a possibility. The lifting of the toy is an expression of something else. Most often the reason has to do with the child's feeling about his/her relationship with the therapist. Possibly the child wants to test the limits in order to learn what the therapist is made of and how he/she will treat the child in an adversary situation. Perhaps the child is asking if the therapist really likes him/ her enough to give the toy or enough to set and hold limits on the child. Perhaps the child is angry at the therapist and taking the toy is a hostile act. Maybe the child has impulse-control problems; he/she sees an attractive toy, wants it, and takes it. Are there other possible reasons? In any case, the child has probably used this behavior in

the past in an attempt to gain whatever ends the child desires and therefore has a background of experiences with the reactions of elders and peers.

What do you do if the child takes or threatens to take something? First, I would suggest what *not* to do is get into a physical or emotional struggle with the child. Have you ever tried to take something forcibly out of the pocket of an active 7-year-old boy? You might succeed *if* the struggle is playful, *if* the child is not too determined, and *if* you are in good physical condition, but you may not want to risk the "ifs." So when the child asks to take some item from the therapy room or if you observe the child taking something, you might say, "I know you would like to have that, but we have a rule here because if everyone took something, pretty soon there would be nothing left to play with." I would advise the "natural consequences" approach of Rudolph Dreikurs (1964). If, after explaining the rule to the child and the rationale for the rule, the child persists, you would say in a matter-of-fact voice that if he/she takes the toy there will be no toys in the room for the next session. Then do not argue. If the child continues arguing, you can just pretend not to hear. If the child takes the toy anyway, I would suggest that you do not carry the struggle on, particularly in the waiting room where the parent would likely become involved in the issue. Next session you can have the child walk into an empty therapy room. I would not insist on the toy being brought back (that is just one of the material-consumption expenses in the child therapy business) but would state the reason for the empty room. For the next session you could return the toys. The cycle may be repeated as many times as necessary.

If the child takes something and the therapist discovers it later, he/she could say to the child at the opening of the next session something like "The father doll was missing last week and I'm worried that maybe you took it. I just need to let you know that if the toys keep disappearing, then we will have to remove *all* the toys." The child will probably deny having taken the doll. I would not argue with the child, but if I were quite certain that the child took the items, I would follow through with the toy removal plan. I have never had to resort to this extreme.

WHAT DO YOU DO WHEN THE CHILD BRINGS STOLEN ITEMS INTO THE THERAPY ROOM?

There is no single best answer to this question because there are so many variables to consider before you react to the child who brings in a "hot" item. First, how do you *know* that the item is stolen?

Does the child tell you it is? Do you have a strong *suspicion* that the item is stolen because of outside reports of the child's stealing or because the child has a pattern of bringing in items that he/she would be unlikely to own? Do you simply *wonder* whether the item belongs to your child client? Second, your reaction will vary depending on the value of the object. Is it an inexpensive pencil or an expensive watch? Third, did the child steal the item him/herself or did a friend steal it? A fourth variable to consider is how central stealing is to the child's clinical problem. Was stealing a primary complaint at intake or incidental to the presenting problem? Fifth, your response would vary with the communication style you had developed with the child. Are you communicating freely about almost everything? Do you usually introduce topics or wait for the child to take the initiative? Are you communicating directly with language or more symbolically through the play medium? Sixth, your reaction to the child will most certainly be influenced by your experience with and emotional reaction to theft. Have you ever been the victim of a theft? Do you believe stealing is a serious moral transgression or a passing stage for almost all kids—or both?

All of the above variables are peripheral to the actual therapeutic interaction you have going with the child. To know how to respond you have to know why the child is bringing the stolen item into therapy. Did he/she deliberately or inadvertently show you the object? Does the child want to see how you will react as a way of further defining your relationship? For example, the child might wonder if you will behave like a parent and scold him/her or make him/her return the item. Does the child feel guilty and want punishment from you? Is the child wanting to express anger in a way that will provoke you to respond? Is the child trying to show a "cool, macho" image? Is the child guiltless and simply wanting to show off a new possession?

Then too your response would depend on your relationship with the child. A few aspects of the relationship that would influence your response are how freely you communicate, how open you are with each other about discussing a wide range of topics, how safe the child feels with you, how angry the child is with you, and how dependent the child is on you.

Finally, you need to consider the goals of your therapy. If you are trying to increase your child's allocentrism, you might speculate with the child on the feelings of the victim or even have the child role-play the victim. If you are trying to increase the child's self-awareness, you might discuss what the child

was thinking at each step of the theft. If the child stole the item as a hostile act toward the parents, you might help the child find more direct (and less self-destructive) ways to express his/her angry feelings. If it is an inexpensive item and the child had not brought in a stolen item before and it does not seem to be central to what is occurring in therapy, you might ignore it.

The variables and the possible ways you can respond are endless. Perhaps the best first response is to be as noncommittal as possible until you can ascertain a position on the major variables discussed here. Although the answer to the lead question is not given here, this section may help you consider the many facets of the issue. Finally, allow me to pass the buck: Ask your supervisor how he/she would suggest that you respond given all the variables involved.

HOW CAN YOU DEAL WITH THE CHILD'S RESISTANCE TO THERAPY?

When the child in therapy stops playing, stops interacting with the therapist, and withdraws from the session either physically or psychologically, it may be labeled resistance. Temporary withdrawal may be for relatively minor reasons, but resistance is defined here as withdrawal in order to avoid the changes that occur in psychotherapy. All resistance is due to one underlying factor: the child perceives a threat to his/her self and becomes fearful of loss of self.

There are several forces that the child could perceive as a threat to his/her existence. The child's own feelings, which he/she is learning to express in the therapy environment, may threaten to overwhelm him/her. For example, the child might be frightened of not being able to control strong anger, strong sexual feelings, or strong dependency desires. If the child cannot manage these strong feelings and if the child has not developed full trust in the therapist's ability and willingness to prevent the child from being destroyed by these impulses, then he/she will freeze. The child also might become frightened of the therapist if the child becomes very dependent on the therapist before he/she develops trust that the therapist will not take advantage of his/her vulnerability.

In order to deal effectively with the child's resistance, the therapist needs first to appreciate the degree of threat the child must be experiencing to cause such frightened withdrawal (even if it is covered by a sullen anger) and then needs to convey to the child an acceptance of his/her anxiety. The

therapist next attempts to understand the source of threat to the child. To achieve such an understanding is not always easy. The therapist draws on all sources of knowledge about the child—previous therapy session material, history, current family, school and peer problems—whatever might lead to a hypothesis about the source of the child's anxiety.

Once the source is determined, the therapist will not be able to reduce the child's anxiety much by simple reassurance (e.g., "Don't worry about growing into a baby again"); rather, the therapist arranges the environment, including him/herself, to protect the child from whatever is the perceived threat. For example, the therapist could bring the mother into the playroom to reassure the incompletely differentiated (from mother) child that the mother will not desert and therefore destroy the child. Or the therapist may hold a child who threatens to become overwhelmed by aggressive impulses, or *not* hold a child who is threatened with regressive pulls that might completely engulf and wipe out his/her individual existence.

In general, the message the therapist conveys to the child is "You are here and I am here, and I will help you learn that you can experience these frightening things without being annihilated."

HOW DOES THE THERAPIST ANSWER THE CHILD'S QUESTIONS ABOUT OTHER CHILDREN WHO USE THE THERAPY ROOM?

Every time a child asks whether other children use the therapy room, he/she is asking about the relationship between him/herself and the therapist. The child is attempting to understand this new and strange relationship. It is not an easy relationship to understand. The unspoken questions about the relationship may be Is our relationship exclusive? Do I have to share you with other children? Do you have any children of your own? If you see many children, what makes our relationship so special? Are these my toys or do I have to share them (and you) with others? Do you like me as well as or better than those other children? Who in the world *are* you?

I try to answer the child's question directly and honestly. If the child asks, I tell the approximate number of children who use the room (not the names, of course) and the number of children seen by me personally. Asking the child why he/she asks the question will probably draw a blank, but the child's question might make a good entree to touch on the child's concerns about his/her relationship with the

therapist. The therapist might push it a bit further with a comment such as "I guess it's sometimes hard to share the room or me." Or, "You would probably like to have the room and me all to yourself." You should not expect much, or any, response or discussion to follow such a remark, but it will let the child know you are in tune with some of his/her concerns. If the remark is untrue of the child's feelings at the moment, no harm is done; the child either ignores it or thinks, "Well, the guy[gal] is wrong, but he[she] is in there trying."

SHOULD YOU GIVE GIFTS AND SHOULD YOU RECEIVE GIFTS IN A PSYCHOTHERAPEUTIC RELATIONSHIP WITH A CHILD?

The position is that if you feel like giving a gift to your child client, do it. The argument is that if you like someone, it is natural to want to give that person a gift. Giving a gift is simply a way of showing affection for another person, so if you are fond of your child client, then why not be natural and give a gift to that child? There is one important difference between the therapy relationship and a real-life relationship: The therapy relationship is not mutual in meeting the psychological needs of each participant. The psychotherapeutic relationship is to satisfy the needs of the client, not the therapist. There are certain interpersonal behaviors that would be quite natural outside the therapy room but are not appropriate in a therapeutic relationship. The therapist must be extrasensitive to what the behavior means to the client. For example, if you feel like hugging someone of equal status in real life, you might just simply do it. If the person did not like it or attached too much meaning to it, that would be only 50 percent your responsibility, but if you hugged a client who did not like it or attached too much meaning to it, it would be 99 percent your responsibility. You, as a therapist, should know what the behavior means to the client and act according to the client's best interests, rather than to act according to what makes *you* feel good. So with exchanging gifts; the therapist should have a pretty good idea of what a gift exchange would mean to the child and then weigh carefully the answer to the question Is this in the best interest of the child?

The opposite position is to exchange *no* gifts. The argument for this position is that if you do not know what the gift means to the child, then you should play safe and not give it. The problem with this position is that not giving a gift and refusing to accept a gift are also behaviors that may not be in the best interests of the child. In fact, there may be cogent therapeutic reasons why you would want to give or

receive a gift. Some reasons might be the following: The young, concrete-thinking child may need a tangible indication that you care about him/her, especially if the child is accustomed to this means of communication; refusing a gift may be totally baffling and hurtful to a child; if you are using a behavioral model, you might give small gifts as rewards for accomplishing some target behavior.

Over the years I have established some middle-of-the-road rules of thumb for myself that you might consider.

On Giving

1. Give a gift to a child client only if you want to convey a message to the child, such as "I care for you," and if it does not put the child under any obligation to return a gift to you. Be sure the gift is of small monetary value, so that if the child does feel an obligation to return a gift, it is not a burden.

2. If there are no dietary contraindications, a consumable gift such as a food treat has several advantages: (a) food treats are almost universally liked by children, (b) food is less likely to put the child under obligation because he/she does not take home a visible product, and (c) a consumable gift symbolizes the temporary nature of the therapeutic relationship. If you give a more permanent gift, that may somehow convey a message that you expect the relationship to last forever.

3. If a small item strikes you as "just exactly right" for the child, do not obsess yourself into paralysis about the meaning of the gift to the child; trust your instincts a bit and do it.

Michael and I had been building models in the days when plastic models were first on the market. He taught me all I know about model building. Michael loved motorcycles, but at that time there were no motorcycle models on the market in Denver. On a trip to Philadelphia I spotted a plastic motorcycle model in a shop window and *had* to buy it for our work together. He was thrilled; we built it together, and he took it home. Presumably, he is not suffering today from the trauma of that event.

On Receiving

1. If parents ask you, suggest to them that they not bother to have the child give you a gift unless the

child really pushes for it.

2. If the child insists and if you are given the opportunity for some input on gift selection (which is usually not the case), then urge something simple like a small box of candy, a handkerchief, or better yet, something the child has made.

3. When the child gives you a gift, accept it graciously and gratefully, since he/she would probably not understand and would be hurt by a refusal, particularly if the child made the present. If you can possibly display the gift over the next few weeks, the child will know that you really do appreciate and value the gift and the thought behind it.

WHAT CAN YOU DO IF A CHILD TELLS YOU HE/SHE IS GOING TO RUN AWAY?

The very fact that a child tells you he/she is going to run away is a demand for some kind of response from you. Does the child want you to stop him/her from running? Is the child expressing hostility toward you by forcing you into a stressful position? Is the child seeking attention and nurture from you? Is the child shouting out a message to his/her parents? Does the child want you to intervene in a parent-child struggle in which the child feels powerless?

First, you need to assess the level of danger to the child. Factors to consider are the child's age and maturity, the child's means of running away, the thoroughness and practically of the child's plans, and the safety of the place to which the child is planning to run. A runaway threat in therapy is one of the few instances where the child's safety takes precedence over the therapist-client confidentiality. If you believe the child is at risk of being harmed, then you must report it to the parents and, if you judge the child is in imminent danger, to the police. Even if your state child abuse law does not specify reporting a runaway, you are at risk of being liable if the child does run and is subsequently harmed. To preserve your relationship with the child, you need to let him/her know that you are reporting, to whom and why.

If the child tells you of the runaway plans early in the session, you might choose to dig for underlying causes before reporting. It would be fast therapy work, but it is just possible that you could defuse the situation in one session, at least enough to reduce significantly the likelihood of the child actually running. An understanding of the conflicts and feelings the child is having that led to this

desperate step, whether it is done in one session or requires more, calls for hard work on both your and the child's part. Assuming the child is sending a message, what is the message and for whom is it meant? Usually the conflict underlying a desire to run away is an interpersonal conflict most often with the parent(s). When this is the case, a parent-child session or series of sessions is indicated, the goal of which would be to clarify the conflict and work out alternative solutions. Being the child's advocate, you can help empower the child to communicate his/her position and feelings to the parent and effect some change in the impasse.

Occasionally, an older child or adolescent will run away and then contact you by phone. If the child tells you where he/she is or comes to your office for a session, you need to be aware of your legal liability in case you do not report his/her whereabouts and the child is later harmed. In most states running away is no longer a status offense, but you want to be sure that the child is not in danger. In a spirit of openness, I would tell the child about my concerns and urge the child to contact his/her parents so I would not have to. If you have legal questions about any particular aspect of the runaway situation and your part in it, you could contact your local district attorney's office or Community Research Center, University of Illinois at Urbana-Champaign, 505 East Green Street, Suite 210, Champaign, Illinois 61820 (217) 333-0443.

WHAT DO YOU DO IF YOU LEARN ABOUT OR SUSPECT CHILD ABUSE?

Every state in the United States now has a law requiring report of child abuse, so the therapist really has no choice about reporting known or suspected child abuse. Physical and sexual abuse is one of the toughest issues a child psychotherapist can face, because reporting may terminate the helping relationship with the child and family. Because of wanting to continue in a position to help a family, I have often wished, in a short-sighted way, that we did not have child abuse reporting laws. Clearly, though, these laws represent a real advance in our society.

Most abusive behavior represents a cry for help by the parents. Although veiled, their mistreatment of their child(ren) is a desperate way of asking to be stopped from hurting their child(ren) further. Abusive parents are abused children grown up, and once one hears of their own impoverished personal histories, it becomes understandable how they came to be involved in abusive behavior. By and large, abusive parents do not want to treat their children badly.

There are some things you as the child therapist can do to cut down on the risk of doing more harm than good. Acquiring detailed knowledge of the child abuse law and crisis procedures in your state seems the sensible starting place. It is helpful to have a copy of the law, not only to become generally familiar with it but as a reference for particular points as they arise around a specific case. Recently, for example, I had to look up exactly how many years apart siblings had to be in order for their sexual behavior to be considered reportable sexual abuse. Especially useful would be to know how child abuse is defined in your state, on what kinds of information one bases a suspicion, who must report, what protection you have against a liability suit, and what the penalty is for not reporting. Another very important piece of information to have when helping kids and their families is a sense of what happens from the time of the first call reporting abuse until resolution. The best way I have found to obtain this knowledge is to call the number to which you report the abuse (family crisis center, child abuse hot line, whatever it may be called in your area) and set up a visit for yourself in that office. At that visit your contact worker can walk you through the procedure, indicating the various choice points and what may happen at each. If you know what the child and family will be experiencing, you have invaluable information for helping them cope with, at best, a difficult experience.

So how can you help the family? When you think there might be a possibility of child abuse in a new case, it would be prudent to state clearly to the parents and the child the reality of the reporting law. This can best be done at the first appointment when going over the mechanics of therapy, e.g., fees, conditions of confidentiality, and so on. If that prevents the family from continuing the connection with you or your clinic, so be it. When a family breaks off contact with you under these circumstances, it would be in the child's best interest to report what happened back to the referral source. If, however, the family continues working with you and if child abuse indeed does come up, they are less likely to feel betrayed when you report it.

When I think a child client might be abused or at risk of being abused, I generally proceed as follows:

1. When a child tells me he/she is abused, I believe it. Children rarely make up allegations of abuse. To finally risk telling an adult they are being abused and to not be believed puts the children under enormous pressure and further perpetuates abuse by "the system."

2. I will consult with a colleague about the case, especially if the evidence for abuse is indirect, because I may not want to believe that child abuse is really going on. There is almost always a strong wish that abuse is not occurring, because I do not want to see the child harmed and I want to avoid the inevitable stress to the family (and to myself) that follows a report of child abuse. When my colleague confirms what I do not want to hear, I'll take the next step.

3. The most critical message to convey to the child is that it is *not* his/her fault, that he/she is *not* being punished for being bad. The child needs to understand that there are problems in the family and that his/her mother or father is having problems that are adult problems. I explain two important elements of the law to the child at whatever level the child can understand. These elements are that society says adults cannot harm children and that professionals must report abuse or be punished themselves. Also, I will explain to the child what is likely to happen: who will visit, the kind of questions they will ask, where they will take the child and for how long. To explain this, one needs to know about the different possibilities, given different levels of imminent danger to the child.

4. The same points next need to be made to the parents. I prefer to do this in person with the parents and to have the child present. If I do not tell a family everything I know about the circumstances in this case and what is likely to happen and then the parents find out something I did in secret, my chance to work with the family is gone. It is important to convey to the family that I have concern for them, that I want to continue working with them and their child, helping their family in any way possible.

5. I urge the parents to make the abuse report themselves, right there on the office phone. If the parents do not want to make the call, I'll ask them to stay while I do so. At the end of the call I'll ask the crisis worker what will happen next so I can inform the child and parents on the spot.

6. Assuming the parents are continuing to relate to me, I feel it is important to follow up the next day with a home visit or at least a phone call so the parents and the child will know that I am still concerned. This is clearly a time of crisis for the family, and extra sessions are not merely a gesture, but one hopes they can be used to support the child and the family.

These are meant to be suggestions; obviously, real cases do not go this smoothly and you may feel that the procedures I like to follow are all wrong for you and your situation. It is useful, though, to have

some scenario in mind the first few times you are faced with a child abuse crisis so as not to be operating completely in the dark in an emotionally charged situation.

Treating a child and a family in a child abuse situation is a complex affair and every child psychotherapist would be more competent if he/she obtained further knowledge and training in this area. The following are resources for obtaining information about the legal aspects of child abuse:

National Association of Council for Children
1205 Oneida Street
Denver, CO 80220
(303) 321-3963

National Legal Resource Center for Child Advocacy and Protection
American Bar Association
1800 M Street, N.W.
Washington, D.C. 20036
(202) 331-2250

Resources for obtaining information about the mental health aspects of child abuse:

Your nearest medical school; check to see if they have child abuse experts on their faculty.

The Henry Kempe National Center for Prevention and Treatment of Child Abuse
1205 Oneida Street
Denver, CO 80220
(303) 321-3963