CLINICAL INTERVIEWING

THIRD EDITION

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Preface

I advise teachers to cherish mother-wit. I assume that you will keep the grammar, writing, reading, and arithmetic in order, 'tis easy, and of course you will. But smuggle in a little contraband wit, fancy, imagination, thought.

—Ralph Waldo Emerson, *Selected Prose and Poetry*

In the following pages, we aim to take Emerson's advice. This text is a serious examination of clinical interviewing as a professional activity; it includes the "grammar, writing, reading, and arithmetic" of professional interviewing. But in the spirit of Emerson, we have also smuggled in some contraband, and we encourage you to do the same. For our part, we include occasional humor, the practical application of fantasy through skill-building activities, and stories of our own and our colleagues' pitfalls and successes. For your part, we hope you learn clinical interviewing with all the seriousness that an enterprise dedicated to evaluating and helping people who come to you in emotional pain and distress deserves. We also hope you will smuggle a little contraband into the learning process. In particular, we hope the contraband you smuggle in is yourself.

Clinical interviewing is a practical, hands-on activity. It's hard to imagine learning to sit with, listen to, evaluate, and provide professional help to another human being simply by reading a book. Nevertheless, that's exactly the purpose of this book. We hope that by reading it—in combination with classroom activities, practicum or pre-practicum experiences, and feedback from peers and supervisors—budding mental health professionals will learn the art and science, the intimacy and objectivity of clinical interviewing.

This, the third edition of *Clinical Interviewing,* marks the 10th anniversary of its original publication. This fact not only makes us 10 years older, but also, we hope, 10 years wiser. If nothing else, it means we've had a decade to reflect on what we originally wrote. We've made numerous positive changes and updates, which include:

- A stronger multicultural emphasis, with 13 new "Individual and Cultural Highlights" sprinkled throughout the text.
- A continued emphasis on contemporary literature in psychiatry, psychology, counseling, and social work as reflected by over 100 new citations.
- New sections in Chapters 6 and 10 on the science of clinical interviewing.
- A new section in Chapter 7—Intake Interviewing and Report Writing—that includes information on writing intake reports—complete with an intake outline and sample report.
- New sections in Chapter 7 on interviewing clients with chemical dependency problems and trauma victims (with a special emphasis on using motivational interviewing principles and strategies).

Chapter 11

INTERVIEWING YOUNG CLIENTS

Mr. Quimby wiped a plate and stacked it in the cupboard. "I'm taking an art course, because I want to teach art. And I'll study child development—"

Ramona interrupted. "What's child development?"

"How kids grow," answered her father.

Why does anyone have to go to school to study a thing like that? wondered Ramona. All her life she had been told that the way to grow was to eat good food, usually food she didn't like, and get plenty of sleep, usually when she had more interesting things to do than go to bed.

—Beverly Cleary, *Ramona Quimby, Age 8* (1981, pp. 15–16)

CHAPTER OBJECTIVES

As our young clients often remind us, you don't have to know much to realize that interacting with children and teens is often strikingly different from interacting with adults. In this chapter, we provide practical recommendations for interviewing young clients. After reading this chapter, you will know:

- Several special considerations for interviewing children and adolescents.
- How you can modify your interactions—and sometimes even your clothing—to make a good first impression with young clients.
- How to discuss confidentiality, informed consent, referral information, and assessment and therapy procedures with youth.
- A specific technique for talking with young clients about therapy goals.
- User-friendly assessment and information-gathering strategies.
- Methods for reassuring, supporting, and empowering youth.
- Important issues to address when ending sessions with young clients.

To this point, our primary focus has been on interviewing, assessment, and treatment planning with individual adult clients. However, young people present the interviewer with challenges and opportunities that are quite different than those presented by adults. In this chapter, we explore the unique considerations and interviewing procedures necessary for mental health professionals who work with young clients. We also describe difficulties associated with interviewing young clients and suggest strategies for addressing these difficulties.

SPECIAL CONSIDERATIONS IN WORKING WITH CHILDREN

When working with children, it can be hard to stay balanced and objective. For example, there is an unfortunate tendency for adults to view each individual child as primarily a "good kid" or "bad kid." If interviewers succumb to this tendency, it often results in dreading the arrival of some (bad) child clients, while celebrating the arrival of other (good) child clients.

Similarly, interviewers, teachers, and other adults frequently either overidentify or underidentify with children. Some adults see themselves as fully capable of understanding children because of a strong belief, "I was a kid once and so I know what it's like." Adults suffering from this overidentification may fail to set appropriate boundaries when necessary, project their own childhood conflicts onto children, and/or be unable to appreciate unique aspects of children with whom they work. Other adults who underidentify with children may experience children as alien beings—not yet fully part of the human race. Adults suffering from underidentification may talk *about* a child who is sitting three feet away, as if the child were not even in the room. They also might become condescending, rigid, out of touch with issues children face, and/or unrealistic in their fears or expectations.

Children are *not* just like us, nor are they like we were when we were younger. Though different, they are not unfathomable creatures either. Instead, children are somewhere in the middle—rapidly developing, fully human, deserving of respect and age-appropriate communication and information.

To effectively interview children, there are both educational and attitudinal requirements. We encourage mental health professionals to consider their work with children as a form of cross-cultural counseling (J. Sommers-Flanagan & Sommers-Flanagan, 1997). You need to be familiar with basic cognitive and social/emotional developmental theory and have had some exposure to applied aspects of child development (i.e., you should have spent some time with children in either a caretaking or emotionally connected manner).

Additionally, effective child interviewers feel some degree of affection toward children. If children frighten, intimidate, or irritate you, it may be that you should explore these reactions by getting some counseling before you begin directly working with children. Another danger sign is a tendency to repeatedly get overly involved in children's lives. Signs of overinvolvement include continuous fantasizing about adopting or rescuing children in difficult circumstances or actually breaking traditional boundaries and doing things for children that are outside the parameters of the professional relationship. Overinvolvers need to achieve some understanding of themselves in this area and find other ways to meet their needs to rescue and provide extensive nurturing before working therapeutically with children.

A healthy professional and psychological balance is especially necessary when working with children. Children are uniquely able to push our buttons, throw us off balance, and trigger our unconscious unfinished business. Making this balance even more essential is the fact that children constitute a very vulnerable population. Adult clients most likely possess greater maturity, more education and life experience, and have a more fully developed sense of themselves. They are usually more able to defend and advocate for themselves. They have more resources and are considerably more autonomous than children. Most adults can extricate themselves from manipulative or ineffective relationships with mental health providers, but most children cannot. Most adults can express their disappointments and needs in a way that makes sense to the counselor; often, children cannot or will not communicate so directly, and when they do, they are sometimes ignored. For all these reasons, we must be especially attuned to the skills, education, and attitudes necessary to work effectively with children.

The remainder of this chapter is organized based on interviewing stages identified by Shea (1998) and discussed in Chapter 6. Because interviewing children usually requires involving the child's caretaker(s), the stage model becomes a bit complicated. Time management is important. For the initial interview, you may need to schedule an extended session so the child has adequate time for self-expression and the caretakers also feel their concerns are sufficiently addressed.

When it comes to working with young clients, this chapter merely scratches the surface. Students who want to work extensively with young clients need much more education and training. As usual, additional readings and professional resources are listed at the conclusion of this chapter.

THE INTRODUCTION

Many, if not most, young people do *not* seek mental health services willingly (Giuseppe, Linscott, & Jilton, 1996; Richardson, 2001). It is unlikely they will be the ones making the initial call to request a clinical interview and/or counseling. Generally, children are referred to a mental health professional's office by their parents, guardians, caretakers, or school personnel. They may or may not have any advance ideas about whom they will meet with and/or the meeting's purpose. In some cases, they may not think there is anything wrong in their world or, even worse, they may not have been informed in advance that they have a counseling appointment. In other cases, they may be very clear regarding their distress or the distress others are experiencing because of them.

With minors, the role of the caretaker (parent, grandparent, stepparent, foster parent, older sibling, group home manager) in the interview is central and requires conscious attention. Some caretakers assume they will be present during the entire interview, and others assume they will not be present. In most cases, this determination should be made based primarily on the interviewer's assessment of what would be best given the presenting problem, child's age, and relevant clinic or agency policies. Often, experienced interviewers arrange to spend time with the caretakers and child first, allowing time for meeting with the child alone as well. Depending on theoretical orientation and the child's age, some interviewers also meet alone with the parents or caretakers.

The arrangements you make for the initial interview communicate important messages to the child. An interviewer who meets alone with caretakers may be perceived as an agent of the caretakers (or an alternative authority figure). This is especially true with adolescents. On the other hand, there are possible problems associated with not meeting with parents separately (F. Kelly, 1997). Sometimes, it is important to hear background information about the parents or the situation that is inappropriate for the child to hear. Also, it is preferable to meet with angry, hostile parents alone rather than risk subjecting the child to a barrage of negativity from the parents. However, if the child is your primary client, the child deserves, at least generally, to know what is said about him or her. Letting caretakers know that you will be summarizing and sharing any information you feel is important with the child helps set a meaningful boundary. If you are working directly with a child or adolescent, then the young person is your client to whom you are responsible for confidentiality.

CASE EXAMPLE

Sandy Smith, a 13-year-old child of mixed racial descent, was adopted by a mixed-race couple who later divorced. She was a gifted violinist and athlete but had begun "hanging with the wrong crowd." Her father and stepmother insisted on getting counseling for Sandy. Her mother and stepfather were less eager, but felt something must be done about her increasingly defiant behavior. All four parent figures plus Sandy's 3-year-old half brother arrived at the counseling office. Sandy's father was going to pay for the counseling and was clearly planning to talk with the counselor alone before anyone else was interviewed.

The counselor gave Sandy's father a warm smile, but oriented to Sandy in the waiting room, saying, "Hi. You must be Sandy. Looks like you have a pretty big fan club along with you today."

Sandy shrugged and mumbled, "Hi."

The counselor then said, "How about if everyone comes back for a few minutes so I can meet everyone?"

Sandy's father asked pointedly, "Can I just see you first for a couple minutes?"

The counselor again smiled warmly and said, "You know, it would really be better if we all come in and everyone hears a little bit about how I work with young people (significant smile is sent in Sandy's direction). Then, if at the end of our time, we haven't gotten to some of your concerns, Mr. Smith, we'll think of ways to get to them. Would that work for you?"

Mr. Smith nodded, a little reluctantly, and the whole group proceeded to the counselor's office.

In this example, the interviewer was clear in advance regarding her plan, and she was capable of setting limits with a dominant (and perhaps controlling) parent. Without a clear plan and assertive behavior, interviewers dealing with children and families may end up having a dominant family member control the interview and even the therapeutic plan. Although this may be revealing, generally it's better for the mental health professional (rather than the parent) to guide the treatment plan.

The child's guardians have many legal and moral rights, but it is essential that your client—the child—realize that your primary allegiance is to him or her. This realization can be seriously hampered by too much attention to the caretakers' desires and concerns and not enough attention to the child. Therefore, early on, preferably even while appointments are being made, it is good to be clear about the role caretakers will play in the upcoming interview. For example, an early telephone conversation with a mother who wants to bring her 12-year-old son for counseling might proceed like this:

Interviewer: "Hello, my name is Maxine Brown. I'm returning your call to the Riverside Counseling Center."
Mom: "Oh yeah, I called yesterday because I want to set up an appointment for my 12-year-old son. I'm raising him by myself, and I just can't seem to get through to him. He's been so angry lately. He's impossible to deal with. When can I get him in?"
Interviewer: "Well, I have open times next Monday at 1:00 P.M. and 3:00 P.M."
Mom: "Great. I'll take 3:00 P.M."
Interviewer: "Sounds good. (Therapist explains fee arrangement, office forms to be completed, and directions to the counseling center.) Also, I'd like to let you know that at the beginning of the session, I need to meet with both you and your son together. During that time, I'll talk with both of you about office red tape as well as counseling goals and how I like to work with young people. Does that sound okay to you?"
Mom: "Yes, I guess so. So you want me to actually come in, too? I thought I could just drop him off and run back to work."
Interviewer: "Yes, actually it's very important for me to meet with both of you to review the goals of counseling. That should take about 20 minutes or so. Then I'll meet with your son alone so I can get to know him a bit and we can begin working together. While I meet with him, you can either run back to work or do some paperwork in the waiting room. Okay?"
Mom: "All right."
Interviewer: "Great. I'll look forward to meeting with both of you on Monday."

Whether directly on the telephone (as in the preceding example) or at the outset of the interview (as in the first example), it is essential to control caretaker involvement in therapy. Each situation is different, but establishing your own or your agency's general policies and guidelines early clears up potential confusion and allows you to develop a working alliance with the child (and parent).

THE OPENING

The reason that all the children in our town like Mrs. Piggle-Wiggle is because Mrs. Piggle-Wiggle likes them. Mrs. Piggle-Wiggle likes children, she enjoys talking to them and best of all they do not irritate her.

—B. MacDonald, *Mrs. Piggle-Wiggle*

This section describes effective strategies for getting acquainted with young clients. Child interviews include two general goals. First, learn as much as possible about the child (Greenspan & Greenspan, 1991). Second, as you learn about the child, you have a simultaneous goal of establishing a warm, respectful relationship with the child. Because children and adolescents are likely to be unfamiliar with clinical interview procedures and may be shy, reluctant, or resistant, relationship-building can present a special challenge. Interviewers can carry this burden more easily if they follow Mrs. Piggle-Wiggle's lead: Young people quickly perceive whether mental health professionals like them and enjoy them. They also readily notice if professionals are threatened or irritated by child/adolescent attitudes and behaviors. If young clients do not believe they are liked or respected, there is much less chance that they will listen, open up, or, if they have any choice in the matter, choose to continue therapy (Hanna, Hanna, & Keys, 1999; M. J. Lambert, 1989; Ricks, 1974; S. Stern, 1993).

First Impressions

First impressions are very important. Counselors need to be friendly, active, interesting, and upbeat. This usually begins with the waiting room greeting. Although it may be tempting to engage in adult talk with parents first, doing so can make rapport-building with young clients more difficult. Make efforts at connecting with young clients when initially meeting them in the waiting room. A wave or a handshake and a friendly "Hi, you must be Whitney" is a good start, followed by more quick exchanges, such as "It's very nice to meet you" or "How's it going today?" or "Great biking

weather out there, huh?" You are sending the message that you have been looking forward to meeting the young person and are eager to spend time with him or her. A little adult chatter is fine, too, as long as you do not forget to connect with the child.

After you move from the waiting room into the office, maintain some focus on the young person. Children, even when cooperative and open, are best considered involuntary clients, because, for the vast majority, seeking therapy is not their idea. As with any involuntary client, the interviewer is wise to introduce a few creative choices within the interview frame. For instance, you might say something like:

1. "Hi, Bobbie. Your mom and stepdad are going to fill out some boring old paperwork while you and I talk together. I have some toys in this closet. You can pick two to bring with us to my office."
2. "Well, Sarah, I need to explain three important things to you. One is about how we will spend our time together today. One is about a word called *confidentiality*. And one is about why my office is so messy. Which one would you like me to talk about first?"

Another way to introduce choice with young people is to offer food or drink. The options, depending on your values, budget, and setting, might include milk, hot chocolate, juice, sports drinks, or sodas. Snacks might be pretzels, chips, granola bars, fresh fruit, crackers, candy, or yogurt. To feed or not to feed is a professional question we do not discuss at length in this book. Suffice it to say, feeding young people builds relationship. Hungry young people can think of little else besides their hunger, and watching the process of acceptance and consumption can provide a great deal of clinical information. Food may be an especially important therapy tool when young children are meeting with you immediately after school. Although we try to avoid beverages with caffeine and highly sugary foods, other therapists we know use such items after obtaining parental permission.

Office Management and Personal Attire

Young clients can be turned on or off by physical surroundings. When interviewing youth, place a few "cool" items in clear view. Depending on clients' ages, items such as popular sports cards, fantasy books, playing cards, drawing pads, clay, and hats can be useful to have in your office. Trendy toys are always the mark of a cool counselor, but you have to make a commitment to being up on the trends. At the time of this writing, Gameboys, Harry Potter books, and Spider Man are in. Beanie Babies and trolls are out. By the time you buy this book, you will be left to your own devices to discover what is cool. More generically, soothing items, such as puppets and stuffed animals, can increase young clients' comfort level. Sometimes, teenagers may comment negatively about such items because they are normally associated with younger children, but the comments are probably just a cover for their comfort and dependency needs (Brems, 1993). Overall, the office should be interesting and youngster-friendly to whatever extent possible.

Rather than drawing attention to objects of interest in the office, let young clients notice particular items on their own. Their natural exploratory behavior helps them become comfortable in a new setting. In addition, their reaction to office items is valuable assessment information. For example, some children orient to the sports cards and begin estimating their resale value; others cuddle up with pillows and stuffed animals; and still others ignore everything, appear overtly sullen, and roll their eyes if someone tries

to talk with them. Some clients are not able to keep their hands off certain items. In fact, materials may need to be placed in drawers or boxes if they become too distracting; others, such as clay or a doodle pad, can give the client something to "mess around with" while talking with the therapist. Having something to hold or squeeze or draw with can reduce client anxiety (Hanna et al., 1999).

Young clients in general and adolescents in particular respond better to therapists who, even in their choice of dress, indicate they can connect with the adolescent world. This does not mean you have to shop at Old Navy or Eddie Bauer. Nonetheless, we recognize that one of the most successful female therapists we know attracts and maintains relationships with difficult adolescent girl clients, at least in part, because she dresses "way cool." If you are wondering how we know this bit of information, it is because teens seen in therapy often compare notes; they talk with each other about their respective "shrinks" and often offer therapist progress reports pertaining to their friends who are seeing other therapists. Listening to these assessments can be informative.

In contrast, some clothing choices may be "uncool." For example, traditional, conservative attire (suit jacket, shirt, and tie) may be viewed by adolescents, especially those with oppositional and conduct disorder behaviors, as signs of a rigid authority figure. Delinquent adolescents have strong transference reactions to authority figures, and such reactions can impair or inhibit initial rapport (Spiegal, 1989).

Generally, more casual attire is recommended when interviewing young clients. This is not to suggest that young clients cannot overcome their reactions to a therapist's clothing choices. However, when working with youth, it is useful to eliminate even the most superficial obstacles to rapport whenever possible. Although interviewers need to present themselves and their work in a way that feels personally and professionally authentic, keeping an eye to youth-friendly accessories can be helpful.

Discussing Confidentiality and Informed Consent

Many young people (especially teens) are sensitive to personal privacy. Therefore, you need to discuss confidentiality at the *beginning* of the first session. In addition, teenagers sometimes believe the interviewer is working as an undercover agent for their parents; they may fear that what they say in private will be reported back to caretakers or authority figures. Although written informed consent forms should be read and signed before an initial session, discuss confidentiality immediately after child and parents are comfortably seated in the office and have finished basic paperwork (K. Gustafson, McNamara, & Jensen, 1994; Handelsman & Glavin, 1988; Plotkin, 1981). When working with teens or preteens, we recommend an approach similar to the following:

> "Willy, you and your mom both may have read about confidentiality on the registration forms, or you may have heard the word before, but I want to discuss it with you for a few minutes. Confidentiality is like privacy. That means what you say in here is private and personal. Of course, I have a supervisor and I keep files, but my supervisor also will keep information private, and our files are locked and secure.
>
> "I will keep what you say to me private . . . I won't talk about what you say to me outside of here. Now, there are a couple of situations where I won't keep secrets. For example, if either of you is dangerous to yourself or to anyone else, I will not keep that information private. Also, if I find out about child abuse or neglect that has happened or is happening, I will not keep that information private either.

That doesn't mean I think there's anything dangerous going on with you two; I'm just required to tell you about the limits of your privacy before we get started. Do either of you have any questions about confidentiality (privacy) here?

"Now (while looking at the child/adolescent), one of the trickiest situations is whether I should tell your mom and dad about what we talk about in here. Let me tell you how I like to work and see if it's okay with you. (Look back at parents.) I believe your daughter (son) needs to trust me. So, I would like you to agree that information I give to you about my private conversations with her (him) be limited to general progress reports. In other words, aside from general progress reports, I won't tell you what your child tells me. Of course, there are some exceptions to this, such as if your child is planning or doing something that might be very dangerous or self-destructive. In those cases, I'll tell your child (turn and look to child) that he (she) is planning something I think is dangerous and then we'll have everyone (turn back to parents) come in for an appointment so we can all talk directly about whatever dangerous thing has come up. Is this arrangement okay with all of you?"

Teenagers need to hear how privacy is maintained and protected. Further, most parents appreciate their children's need to talk privately with someone outside the home and family. In the case of a diagnostic interview where results are shared with a referral source or a child study team, the child should be made aware of this. In rare cases where parents insist on being in the room continuously or constantly apprised of therapeutic details, a family therapy or family systems interview and intervention is probably most appropriate.

School and agency mental health professionals must also be very clear regarding the constraints of the position they hold and the system they work for. Young clients often assume their life is an open book. Assuring them of confidentiality and carefully explaining its limits enhance their sense of being respected participants in the relationship.

Confidentiality laws regarding working with minors vary from state to state. All mental health professionals and trainees should review their paperwork and practices with regard to regulations in each particular setting and state.

Teenagers may respond better to a modified version of the previous confidentiality disclosure. More relevant and sometimes humorous examples can be provided. For example, when turning to the teenager, the following statement may be made:

> "So, if you're planning to do something dangerous or destructive, such as holding the mailman hostage, it's likely that we'll need to have a meeting with your parents to talk that over, and it's the law that I would need to warn your mailman. But day-to-day stuff that you're trying to sort out, stuff that's bugging you, even if it's stuff *about* your parents or teachers or whoever—we can keep that private."

Setting confidentiality limits may be controversial, but all interviewers must determine (preferably beforehand) if, when, and how they might inform parents if they become aware of a teenager's dangerous behavior (K. Gustafson, McNamara, & Jensen, 1994). If written confidentiality and informed consent statements are used, both parents and young clients should sign them, indicating their understanding and willingness to cooperate.

Whatever your situation, we recommend you talk about confidentiality limits with

children of all ages. Confidentiality is a unique aspect of therapeutic relationship development. For example, Leve (1995) states:

> There is one last aspect of a therapeutic relationship that children find very unusual. Children are almost never told that what they say to an adult will be held in strict confidence and never be told to another adult. This indicates that the therapist respects the child in a way they have never before experienced, and it is a signal that the child's thoughts and actions are important, probably in a way they never dreamed possible. As a result, children sense that therapy is an experience very different from other adult relationships and that it will have an unusual importance in their life. (p. 245)

As an interviewer, you should develop your own way to talk with young people and their parents about counseling and confidentiality. Rehearsing different approaches to talking with clients about this important issue can help (see Individual and Cultural Highlight 11.1).

Handling Referral and Background Information

Teachers, family members, or others who are bothered by or concerned about a particular child's behavior frequently refer difficult youth for therapy or evaluation interviews. In most cases, the interviewer should tell the child why he or she was referred. Keeping secrets about why the youth was sent to therapy can harm the working relationship. Remember, the referral source, no matter how distraught, is not your primary client.

For example, a school counselor may be contacted by a concerned teacher who, undetected, observed a student throwing up in the bathroom after lunch. At the teacher's request, the counselor may invite the student to stop by for a visit. We believe it would be a mistake to fail to mention the reason for concern. Of course, you must make your policies along these lines very clear to informants and referral sources. In some cases, the referral information source may need to remain anonymous, but the information itself, in the vast majority of situations, should be tactfully, compassionately, and honestly conveyed.

After discussing confidentiality and informed consent, it is time to begin to get an idea of the reasons the client has come for therapy. Common reasons for bringing preschool- to latency-age children in for clinical interviews include:

- Moodiness, irritability, or aggressive behavior patterns.
- Behaviors that caretakers believe to be abnormal or especially irritating.
- Unusual fears or tendencies to avoid age-appropriate play activities.
- Unusual or precocious sexual behaviors.
- Exposure to trauma or difficult life circumstances, such as divorce, death, or abuse.
- Hyperactivity or problems with inattentiveness (predominantly boys).
- Enuresis or encopresis.
- Custody battles between parents.

This list is neither exhaustive nor comprehensive. It is intended to help you glimpse a typical young child referral. Like younger children, older children and adolescents

INDIVIDUAL AND CULTURAL HIGHLIGHT 11.1

Individualizing Introductory Statements with Young Clients

In this chapter, we provide sample statements for introducing yourself to young clients and introducing interviewing and counseling to young clients. These statements are a good start, but you can come up with better opening statements for yourself. Whatever you say the first few minutes should fit your personality. If you're using some standard opening with young clients, but the opening is uncomfortable for you, children will sense that there's something unauthentic or phony about you. Therefore, this activity involves formulating opening statements to use with young clients that fit with your personality. Of course, these statements should be somewhat serious and not offensive. They should focus on:

1. Introducing yourself to the child and family.
2. Describing confidentiality and its limits to the child and family.
3. Describing any other feature of interviewing and counseling (e.g., psychological assessment).

Take a few minutes to think about the words you'd like to use when discussing these issues with children. Now, shift your focus and imagine how you might change your introductory comments depending on the ethnic or cultural background of a particular child. How would your introductory comments change if you were working with an American Indian, African American, Asian American, or Hispanic child and family? What issues do you think would rise to the surface and require a comment from you? If you have an ethnically diverse background, imagine the differences that might arise if you were working with a White child versus someone from your own background. Discuss these issues with your class or classmates.

Besides the fact that youth itself can be considered a culture, many young people in the United States have the challenging task of living in one culture at home and another at school and in their social lives.

One in five children in the United States is a child of an immigrant (Wax, 2001). The stresses and strains of fitting in are sometimes magnified by having parents or caretakers who speak a different language and have customs different from people at school and in the neighborhood. Interviewers should not make assumptions about immigrant families or young people. It can be quite harmful to ignore the potential intergenerational stress created by being immigrants. It can also be harmful to assume that the immigrant family is suffering because of the bicultural demands it faces. The challenges might make family life interesting, or they may be daunting and painful. The wise interviewer finds ways to assess this particular dynamic. You might make observations and ask gentle, opening questions such as:

"I notice your mom is wearing a traditional H'mong skirt, Tu. But you've got on jeans and a T-shirt. Do you dress traditional sometimes?" or "I notice your parents have a kind of cool accent. Do you guys speak Russian or English at home usually?"

Making a few observations that are neutral or slightly positive and following that with a question about the young person's cultural involvement communicates that you are willing to ask about and listen to the struggles and points of pride involved in being a family spanning two or more cultures.

usually do not request therapy themselves. Common reasons for adolescents to be referred for therapy include:

- Depressive symptoms (usually as recognized by a caretaker or teacher).
- Oppositional or defiant behaviors (usually as experienced by authority figures).
- Anger management.
- Eating disorders or weight problems.
- Traumatic experiences (rape, sexual abuse, divorce, death in the family).
- Suicide ideation, gestures, or attempts.
- A court-order or juvenile probation mandate.
- Substance abuse problems (usually identified by having been caught using or driving under the influence).

Although it is important to have a general understanding of childhood psychopathology and typical complaints, each situation is unique and needs to be addressed with individualized concern. Every child who comes to therapy should be asked about his or her understanding of the visit's purpose. However, it is not unusual for young clients, when asked why they have come to therapy, to give vague or unusual responses:

"My mom wants to talk with you because I've been bad."

"I don't know . . . I didn't even know we were coming here today."

"Because I hate my teacher and won't do my homework."

"I'm here because my mom offered to buy me a new computer game if I came to see you."

"Because my parents are stupid and *they* think I have a problem."

Some young clients simply remain quiet when asked about reasons for counseling; it may be they are (a) unable to understand the question, (b) unable to formulate and/or articulate a response, (c) unwilling or afraid to talk about their true thoughts and feelings with their parents in the room, (d) unwilling or afraid to talk openly about their true thoughts and feelings with a stranger, or (e) unaware of or strongly resistant to admitting personal problems.

Resistant or nonresponsive children present interviewers with a very practical difficulty. How can you obtain information and begin a working alliance if the client is reluctant to speak, let alone expound on the problems in his or her life? A focus on wishes and goals, such as described next, can facilitate engagement and bypass resistance by engaging the child in a positive interaction.

Wishes and Goals

To explore core client problems using the wishes and goals strategy, make a statement similar to the following, with the parents (or caretaker) and child present (unless the child is about 6-years-old or younger, in which case you may simply meet with the parents to focus on parenting strategies):

"I'm interested in the reasons you're here and so I want to ask you about your goals for counseling. Usually, even though parents (look at parents) may have

some very clear goals in mind for counseling, I like to start by asking the youngest person in the room. So, Renee (look at the child), you're the youngest one here, so you get to go first. If you came to counseling for a while and, for whatever reason, your life got better, what would change? In other words, what would you like to have get better in your life?"

Some children/adolescents understand this question clearly and respond directly. However, several potential problems and dynamics may occur. First, the child may not understand the question. Second, the child may be resistant, or reluctant to respond to the question because of family dynamics. Third, the child may focus immediately on his or her perceptions of the parents' problems. Fourth, the parents may begin making encouraging comments to their child, some of which may even include tips on how to respond to the counselor's question. Whatever the case, two rules follow: (a) if the child/adolescent does not answer the question satisfactorily, the question should be clarified in terms of wishes (see the following), and (b) for assessment purposes, the counselor should make mental or written notes regarding family dynamics.

Introducing the Wish

Wishing as an approach to assessing problem areas and obtaining treatment goals from young clients is useful because it involves using a language that young people are more likely to accept (J. Sommers-Flanagan & Sommers-Flanagan, 1995b). For example:

"Let me put the question another way. If you had three wishes, or if you had a magic lamp, like in the movie *Aladdin,* and you could wish to change something about yourself, your parents, or your school, what would you wish for?"

This question structures goal setting into three categories—selfchange, family change, and school change. Thus, the child/adolescent has a chance to identify personal goals (and implied problems) in any or all three of these categories. Depending on the child and on the parents' influence, there may still be resistance to identifying a goal in one or more of these areas. If there is resistance, the question may be amplified:

"You don't have any wishes to make your life better? Wow! My life isn't perfect, so maybe I should wish to change places with you. How about your parents? Isn't there one little thing you might change about them if you could? (Pause for answers.) How about yourself? Isn't there anything, even something small, that you might change about yourself? (Pause again.) Now, I know there must be something about your school or your teachers or your principle you'd like to have change . . . they can't all be perfect."

Nervous or shy children/adolescents may continue to resist this questioning process. If so, young clients should be given the chance to pass on immediately responding to the wishing question:

"Would you like to pass on this question for now? I'll ask your parents next, but if you come up with any wishes of your own, you can bring them up any time you want."

The purpose of this questioning procedure is to get young clients, in a somewhat playful, provocative, and perhaps humorous way, to share their hopes for positive

change. The interaction can provide diagnostic-related information as well. Usually, clients with disruptive behavior disorders (i.e., attention-deficit/hyperactivity disorder, oppositional defiant disorder, or conduct disorder) acknowledge that the school and parents have problems but admit few, if any, personal problems. In contrast, clients who are primarily experiencing internalizing disorders (e.g., anxiety and depression) identify their own personal problems and goals (e.g., "I'd like to be happier").

Obtaining Parental or Caretaker Goals

After young clients identify at least one way their life is not perfect, or after they have passed on the question, the focus should shift to the parents. Direct interaction and attention to parental concerns is crucial to getting the full picture and to treatment compliance (e.g., if parents do not support therapy or provide reliable transportation to therapy, it will not continue—and to support therapy, they want their concerns addressed). In addition, it is helpful for children and adolescents to watch the therapist become serious and thoughtful when discussing important topics and problems with parents.

When addressing parents, interviewers should take detailed notes; it is important that parents know you are taking their concerns seriously. However, it is equally, if not more, important to limit the number of negative and critical comments parents make about their children, especially during the first session. Usually, three or four problem statements are enough. Setting this limit protects young clients from feeling devastated or overwhelmed by their parents' criticism. If parents indicate they have additional concerns, you can invite them to write down the concerns for you to review later. Another strategy is to shift the conversation by asking parents to name a few of their child's strengths (P. Silverman, personal communication, July 9, 1998). In some cases, after an initial rapport has been established between therapist and child, a separate meeting with parents can be conducted (with the young client's permission) to address parental concerns more completely. Similarly, you can ask young clients if it is okay for their parents to make us a list of parental concerns. If everyone has been informed of how important it is to have this information, and if an initial trusting relationship has been established, there will usually be little resistance to these information-gathering strategies.

Assessing Parents or Caretakers

Sometimes the parents or caretakers who bring children for an interview have more psychological problems than the children. For several reasons, this can be a tricky situation for interviewers of all ages and experience levels. However, it can be especially challenging for those with little family interviewing and counseling experience.

If parents present with extreme psychological problems or display very disturbing interaction patterns with their children, you may be professionally obligated to take actions. These actions can range from mild to extreme, depending on your perception of the severity of the parent-child problem. For example:

- You may be able to ignore the unhealthy patterns during the first session and wait until rapport has been established before providing feedback.
- You may need to provide some gentle feedback immediately.
- You may need to gather further assessment information to determine if the child is in immediate danger.
- You may need to inform the parent of your obligation to report child abuse and proceed to do so.

In most cases, it is best for you to wait for additional sessions and greater rapport to give feedback and suggestions for parental change. However, sometimes, if unhealthy behavior patterns are mild and the parent seems open to constructive feedback, you may be able to provide that feedback immediately in the first session. Alternatively, you may be able to assign some therapeutic homework for addressing the problematic behavior.

Research has shown that there are three common parenting styles: authoritarian parents, permissive parents, and authoritative parents (Baumrind, 1975; Coloroso, 1995). *Authoritarian* parents are also referred to as *brickwall* parents because they make rules that are etched in stone and govern the home with a dictatorial "my way or the highway" style (Coloroso, 1995). *Permissive* parents are often referred to as *jellyfish* parents because they have difficulty setting and enforcing family rules and values. Children of jellyfish parents tend to rule the house. In contrast, *authoritative* parents have been labeled *backbone* parents because they set reasonable rules, parent democratically, and listen to their children's ideas, but remain in a position of final authority. Unfortunately, all too often, parents find it much easier to take brickwall or jellyfish approaches to parenting, but parents who engage in backbone or authoritative parenting score higher on measures of self-actualization (Dominguez & Carton, 1997). It can be useful to assess whether a young client's parent is an authoritarian, permissive, or authoritative parent.

Divorce, remarriage, and stepfamily life are realities for many children. Assessing the family system and its unique qualities is important when working with young clients. For some children, divorce is painful, while for others, it is a significant relief. Similarly, parental remarriage and new blended families can bring both joy and terror to children's lives. To deepen your understanding of these issues in children's lives, we recommend that you read divorce information from the children's perspective (R. Sommers-Flanagan, Elander, & Sommers-Flanagan, 2000; see Individual and Cultural Highlight 11.2 and Suggested Readings and Resources at the end of this chapter).

Managing Tension

During the wish-making procedure, tension may rise, especially if children/adolescents are asked to make wishes about how they would like to see their parents change. Despite this tension, child/adolescent wishes about their parents area crucial part of the assessment and information-gathering process. Additionally, it is reassuring to most young clients to hear the interviewer say things like "I guess your parents aren't perfect either." In addition, focusing on parental behaviors at the outset of therapy may provide a foundation for working on changing parental behaviors through counseling. Finally, as suggested previously, parent-child interactions during this goal-setting procedure sometimes reveal interesting family dynamics. For example, we have observed children who seem afraid to comment on their parents' behavior (and their parents do not reassure them), and we have seen children who are rather vicious in their wishes for parental change.

If, after help, encouragement, and humor, and after passing on their initial opportunity to wish for life change, the young client is still unable or unwilling to identify a personal therapeutic goal, the prognosis for counseling may not be promising.

Discussing Assessment and Therapy Procedures

After initial concerns and goals have been identified, a brief review or explanation of interview procedures is appropriate. Depending on the situation, you may choose to

INDIVIDUAL AND CULTURAL HIGHLIGHT 11.2

Children and the Culture of Divorce

The following Divorced Children's Bill of Rights is a document written to divorced and divorcing parents from the child's perspective. It is included here to give you a deeper sense of children's views of the culture of divorce.

The Divorced Children's Bill of Rights

I am a child of divorce. I hold these truths to be self-evident:

I have the right to be free from your conflicts and hostilities. When you badmouth each other in front of me, it tears me apart inside. Don't put me in the middle or try to play me against my other parent. And don't burden me with your relationship problems, they're yours, not mine.

I have the right to develop a relationship with both parents. I love you both. I know you will sometimes be jealous about that, but you need to deal with it because you are the adult and I am the child.

I have a right to information about things that will affect my life. If you're planning on getting a divorce, I have a right to know, just as soon as possible. Likewise, if you're planning to move, get remarried, or any other major life change, I have a right to know about it.

Just as I have a right to basic information about my life, I also have a right to be protected from inappropriate information. This means you shouldn't tell me about sexual exploits or similar misbehavior by my other parent. You also should not apologize to me—*for my other parent*—because this implies a derogatory judgment of my other parent. If you apologize to me, apologize for yourself.

I have a right to my own personal space in each of my homes. This doesn't mean I can't share a room with my brother or sister, but it does mean that I need space and time of my own. I also need some special personal items in my own space . . . and this just might include a picture of my other parent . . . don't freak out about it.

I have a right to physical safety and adequate supervision. I know you may be very upset about your divorce, but that doesn't mean you should neglect my needs for safety and supervision. I don't want to be home alone all the time while you're out dating someone new.

I have a right to spend time with both parents, without interference. My right to spend time with each of you shouldn't be dependent upon how much money one of you has paid the other. That makes me feel cheap, like something you might buy in a store.

I have a right to financial and emotional support from both my parents, regardless of how much time I spend with either of you. This doesn't mean I expect twice as much as other kids get, it just means that you should stop worrying about what I got from my other parent and focus on what you're providing me.

I have a right to firm limits and boundaries and reasonable expectations. Just because I'm a child of divorce doesn't mean I can't handle chores, homework, or other normal childhood responsibilities. On the other hand, keep in mind that even though I may have a little sister or brother (or step-sister or step-brother), I'm not the designated babysitter.

I have a right to your patience. I didn't choose to go through a divorce; I didn't choose to have my biological parents live in two different homes, move away, date different people, and in general, turn my world upside down. Therefore, more than most children, my life has been beyond my control. This means I will need your help and support to work through my control issues.

(*continued*)

INDIVIDUAL AND CULTURAL HIGHLIGHT 11.2 (continued)

Finally, I have a right to be a child. I shouldn't have to be your spy, your special confidant, or your mother. Just because you hate to talk to each other, I shouldn't have to be your personal message courier. I exist because you created me. Therefore, I have a right to be more than a child of divorce. I have a right to be a child whose parents love me more than they've come to hate each other.

Note. From "The Divorced Children's Bill of Rights" [Guest editorial], by J. Sommers-Flanagan, 2000, *Counseling Today,* p. 9. Reprinted with permission from the American Counseling Association.

send parents to the waiting room with an assignment or questionnaire (e.g., a developmental history questionnaire and a problem behavior checklist). If you need a direct interview with parents, young clients can be given drawing assignments or questionnaires to complete in the waiting room. In most cases, it is useful to spend individual time with an adolescent and then to have parents return for 5 to 10 minutes at the end of the time to review therapy or follow-up procedures (e.g., appointment frequency, who will be attending appointments, or even, time permitting, a description of specific treatment approaches such as anger management or treatment of depressed mood).

THE BODY

After obtaining child and parent versions of problem areas and possible treatment goals, it is time to shift to the body of the interview. Depending on developmental and temperamental factors, children are more or less verbal. Therefore, anyone planning to communicate fully and effectively with children must develop and be comfortable with a wide variety of methods. Textbooks, graduate classes, workshops, and even core emphases in graduate programs focus exclusively on assessment and therapy strategies with children. An effective child interviewer is familiar with principles and procedures far beyond what is included in this brief chapter (Priestley & Pipe, 1997).

User-Friendly Assessment and Information-Gathering Strategies

The purpose of formal assessment or evaluation procedures is to obtain information about client functioning that may be used to make diagnoses and treatment recommendations and/or facilitate therapy (Peterson & Nisenholz, 1987). While many mental health professionals use traditional, formal assessment procedures (e.g., intellectual and personality testing, questionnaires) when interviewing children, many do not. Those who do not sometimes have negative attitudes toward assessment or view formal assessment as interfering with the therapy process and with understanding the "whole life of the child" rather than narrow diagnostic aspects (Gaylin, 1989; Goldman, 1972).

Young clients often express criticism and/or sarcasm when asked to participate in traditional assessment (e.g., "This test is totally lame"). They may resist completing the instruments fully and thoughtfully. Fortunately, there are alternatives to using formal assessment procedures for obtaining information. The following procedures help interviewers gather information, while at the same time, capture client interest and cooperation. Because these techniques can facilitate rapport and trust, they usually have a positive effect on cooperation with and validity of subsequent traditional, self-report assessments (J. Sommers-Flanagan & Sommers-Flanagan, 1995b; Shirk & Harter, 1996). Using these qualitative information-gathering procedures can increase youth cooperation with therapy and provide the interviewer with assessment information. They are not a replacement for formal assessment procedures, but add a great deal of information and simultaneously enhance the working relationship.

What's Good (Bad) about You?

A relationship-building assessment procedure that provides a rich interpersonal interaction between young clients and counselors is the "What's good about you?" question and answer game (D. Dana, personal communication, September 1993; J. Sommers-Flanagan & Sommers-Flanagan, 1997). The procedure also provides useful information regarding child/adolescent self-esteem. Initially, it is introduced as a game with specific rules:

> "I want to play a game with you. Here's how it goes. I'm going to ask you the same question 10 times. The only rule is that you can't answer the question with the same answer twice. So, I'll ask you the same question 10 times, but you have to give me 10 different answers."

When playing this game, interviewers ask their young client, "What's good about you?" (while writing down a list of the client's responses). Each client answer is responded to with a "Thank you" and a smile. If the client responds with "I don't know," the response is simply written down the first time it is used; but if "I don't know" (or any response) is used a second time, the interviewer kindly reminds the client that answers can be used only one time.

The "What's good about you?" game provides insights into client self-perceptions and self-esteem. Some youth have difficulty clearly stating a talent, skill, or positive personal attribute. They sometimes identify possessions, such as "I have a nice bike" or "I have some good friends," instead of taking personal ownership of an attribute: "I am a good bike rider" or "My friendly personality helps me make friends." Similarly, they may describe a role they have (e.g., "I am a good son") rather than identify personal attributes that make them good at the particular role (e.g., "I am thoughtful with my parents and so I am a good son"). In this case, the ability to clearly state positive personal attributes is probably evidence of more adequate self-esteem.

Interpersonal assessment data also can be obtained through the "What's good about you?" procedure. For example, we have had some assertive or aggressive children request or even insist that they be allowed to switch roles and ask us the "What's good about you?" questions. We have always complied with these requests as it provides us with a modeling opportunity and the clients with an empowerment experience. Additionally, the manner in which young clients respond to this interpersonal request can be revealing. Youth who meet the diagnostic criteria for conduct disorder (or who are angry with adults) sometimes ridicule or mock the procedure; most other children and adolescents cooperate and seem to enjoy the process.

An optional follow-up to the "What's good about you?" procedure is the "What's bad about you?" query. Although asking young clients "What's bad about you?" is more negative and perhaps controversial, it can yield interesting information. Ask this negative question only five times. Young clients frequently are quicker at coming up

with negative attributes than they are at coming up with positive attributes. In addition, sometimes they identify as negative some of the same traits that were included on their positive attribute list.

During both "What's good about you?" and "What's bad about you?" procedures, observe how clients describe positive and negative traits. For example, adolescents frequently use qualifiers when describing their positive traits (e.g., "I'm a good basketball player, sometimes"). When describing negative traits, adolescents may quote someone else (e.g., an adult authority figure), and they may make an excessively strong statement (e.g., "My teachers say that I'm *never* able to pay attention in school").

Offering Rewards

With disruptive youth, impulsivity and lack of behavioral compliance is a commonly identified problem. As an assessment tool, offering rewards allows interviewers to evaluate how clients might respond to behavioral incentives. The question is whether anticipation of specific reinforcer(s) can motivate a young client to agree to reduce his or her impulsivity and increase behavioral compliance.

After the parents leave the room, ask your client what would happen if he were paid money for discontinuing a problem behavior (e.g., hitting a little brother or sister, leaving the house without seeking permission, forgetting homework at school, or refusing to complete homework). For example:

> "If I were to pay you $10 (or give a $10 gift certificate) next week for completing all homework assignments and always checking with your parents before leaving the house, do you think you could do it?"

This incentive procedure can be conducted in an "as if" mode, or as an actual reward offer.

The offering rewards assessment procedure is used for at least four reasons. First, it helps determine clients' perception of their self-control skills. While some clients are overconfident in their ability to modify their behavior, others are underconfident. Obviously, it is helpful for counselors to know if young clients are being realistic when they describe their personal potential and ambitions.

Second, offering rewards can provide diagnostic information. Specifically, children/adolescents diagnosed with attention-deficit/hyperactivity disorder (ADHD; American Psychiatric Association [APA], 2000) get excited about the money possibility, but quickly fail the homework assignment; sometimes, they fail the homework assignment even before leaving the office (Barkley, 1990). In contrast, children/adolescents diagnosed with oppositional defiant disorder (ODD; APA, 2000) often comply with the counselor's request and simply earn the money (if they feel like it). Finally, children/adolescents diagnosed with conduct disorder (CD; APA, 2000) may try to negotiate or manipulate for additional reinforcers (e.g., more money) or for payment in advance (Rutter & Rutter, 1993).

Third, this technique introduces and then models the importance of informing parents of therapeutic homework (even if the child thinks parents will not approve of the homework) and of the importance of having an objective person monitor the homework success. Although this activity is initially discussed privately with youth, toward the end of the session, the youth is told:

> "Now we need to tell your parents (or teacher) about our arrangement. We need to get their permission and have someone besides you to keep track of your success."

In school settings, where the counselor may have daily access to students, it is still wise to have parents or teachers monitor the desired behavioral change. Involving an "objective" third party, usually one affected by the behavior, can provide additional assessment information.

Fourth, parents and/or teachers can be educated as to the potential usefulness of contingency programs. Sometimes, parents are against using what they call "bribery" to obtain behavioral compliance. If parents object (or perhaps before they object), it can be explained that *bribery* is defined as "paying someone in advance, to do something illegal" (Gordon, 1991). Additionally, you can point out that positive reinforcement is a more efficient behavior modifier than punishment.(Maag, 2001); this can be emphasized by inquiring about positive reinforcers parents receive in their daily lives.

Young clients should be informed that this is only a one-time assessment. Otherwise, clients may expect payments every week. Additionally, young clients may not pay attention to the rules of the homework assignment; therefore, the rules should be clearly written out and clients should repeat the rules of the assignment back to the counselor. Finally, counselors should consider an *effort* reward for children who prove they do not have the ability to sustain attention and effort for a reward that is distant in time (i.e., one or two weeks away).

Inferring Attachment Issues

> *Some people, when they have taken too much and have been driven beyond the point of endurance, simply crumble and give up. There are others, though they are not many, who will for some reason always be unconquerable. You meet them in time of war and also in time of peace. They have an indomitable spirit and nothing, neither pain nor torture nor threat of death will cause them to give up. Little Peter Watson was one of these.*
>
> —Roald Dahl, *The Swan*

Children's lives—their emotional, intellectual, and physical development, their attitudes and beliefs, their opportunities and hindrances—are directly and radically affected by their early caretakers and the quality of the attachment to these figures (Ainsworth, 1989; Bowlby, 1969; D. A. Hughes, 1998). Recently, therapists have become more oriented to attachment dynamics in children and adolescents (Bradford & Lyddon, 1994). Consequently, formal measures of attachment can now be administered to clients at the beginning of or during therapy. However, rather than relying on questionnaire administration, the approach we present here focuses on therapist ratings of client attachment behaviors based on Bartholomew's (1990) reformulation of Hazan and Shaver's (1987) and Bowlby's (1977) attachment models. Specifically, therapists can categorize their young clients' attachment behaviors into one of Bartholomew's (1990) four attachment styles:

1. *Secure prototype:* Clients appear comfortable and open interacting with the interviewer or therapist. They are capable of being emotionally close to others. There are no significant problems with separation from parents or with separation from the interviewer when the session ends.
2. *Preoccupied prototype:* Clients seem to want to be exceptionally close to the interviewer or therapist. There is an apparent desire (spoken or unspoken) for more and more time with the interviewer. Sometimes it seems as if these children/adolescents would gladly go home and live with a therapist after only a few minutes of counseling.

3. *Fearful prototype:* Clients seem to want to be emotionally close, but are fearful of being hurt. This often occurs with children in foster care because they've had numerous experiences of being close to adults and then being emotionally hurt because of a placement change. These clients are likely to put the interviewer through tests of trust (Fong & Cox, 1983).
4. *Dismissing prototype:* Clients appear disinterested in emotional closeness. They like to feel self-sufficient. It is important to distinguish this prototype from the fearful prototype because the fearful prototype may act disinterested to protect himself or herself from emotional hurt. These clients may be more prone to violence and other emotionally distancing behaviors.

Be sure to remember that although attachment styles may have implications for psychopathology, they are not diagnostic entities representative of particular forms of pathology. Instead, these categories help interviewers understand early childhood dynamics that now influence the ways that an individual child/adolescent interacts with others.

The role of protective factors versus risk factors can also be addressed in the context of assessing attachment (Rutter & Rutter, 1993). Although the preceding attachment styles are described in a categorical manner, individual clients display attachment behaviors falling along a continuum within the secure, preoccupied, fearful, and dismissing prototypes. In addition, as the Roald Dahl quote at the beginning of this section suggests, there are rare children who display amazing resilience, even in the face of extreme adverse childhood experiences.

Traditional Assessment and Feedback

In many situations, using traditional assessment procedures with children and adolescents is recommended. Traditional assessment procedures include questionnaires, parent/teacher rating scales, projective tests, intellectual testing, and more. When interviewers use such procedures, children and adolescents are curious about assessment procedures and should be informed of the purpose of particular assessment devices and offered feedback regarding their test scores. Young clients in general and adolescents in particular are likely to feel anxious and distrustful of adults who are evaluating them. Your explanations and feedback need to be carefully geared to both age and level of understanding present in the child. For example, when administering the Minnesota Multiphasic Personality Inventory–Adolescent version (MMPI-A; Archer, 1992) to an adolescent (of at least average intelligence), we might make a statement similar to the following:

> "As a part of our work together, I'd like you to fill out a questionnaire called the MMPI-A. The MMPI-A has been given to thousands of teenagers. It's really long and probably boring to most young people who take it. I'm having you take it because it can give us useful information about certain personality traits you have. You know how sometimes people can have too much of a certain trait or quality, or a healthy amount, or even too little of a particular quality. After you have taken the test, I'll have it scored and we'll look at the results together and I'll explain what the different scores mean. If you want, at the end of counseling, you can take the test again and we can see if there have been any changes."

Obviously, we would not use MMPI-A unless there was a specific purpose for its administration. The reason we have explained its use in the preceding example is that evaluators can be reluctant not only to explain this test, but also to give clients feedback regarding MMPI-A scores. Because the MMPI-A is a test designed to measure pathology, it can be difficult to give constructive feedback to clients who obtain elevated scale scores. On the other hand, just as therapists should avoid writing notes that they would not want their clients to read, therapists should also avoid administering tests to their clients if they are nervous about providing oral or written feedback regarding the client's test results. In almost every case, we recommend showing clients their test profiles and explaining the meaning and interpretation of each clinical scale of the MMPI-A. For example, sample verbal or written descriptions of clinical elevations on MMPI-A scales 1 (hypochondriasis) and 6 (paranoia) are provided next:

> "Scale 1 of the MMPI is called the *hypochondriasis scale.* That's a pretty long and weird word. The scale includes test items primarily related to physical health and physical discomfort. As you probably know, some people are healthier than others are, and some people worry about their health more than others do. People who score high, such as yourself, usually either have some physical health problems or they're worried about having physical health problems in the future. Also, people with scores like yours are more likely than the average person to feel physically sick or physically uncomfortable when under stress. Do these descriptions sound at all like you?"

Notice from the preceding paragraph that the evaluator is giving straightforward and nonpathologizing feedback. Also, whenever giving feedback, we recommend asking clients if the descriptions or interpretations seem to fit for them. Here is another example:

> "Scale 6 of the MMPI is called the *paranoia scale.* Now, just because the scale is called paranoia doesn't mean that people who have high scores are paranoid. In fact, really, the scale is a measure of sensitivity. People with high scores are more likely than the average person to be sensitive to how other people act and what they might be up to. Sensitive people notice little things that an average person might not even notice. As you can see, your scale 6 is a little higher than average. Therefore, I'd guess that you are a keen observer and you notice how other people's actions relate to you. An example might include noticing that other people are laughing and then wondering if maybe they are laughing at you. Also, higher scores on scale 6 are associated with intelligence. So your high score here might mean that on your good days, you are intelligent and sensitive, but on your bad days, days when you're experiencing lots of stress, you can become touchy and suspicious of others. Does any of this seem to fit how you see yourself?"

Perhaps more important than the specific scores obtained by young clients who complete such questionnaires is the manner in which the tests are administered and feedback is provided. Openness with young clients regarding the purpose of formal assessment procedures and results can facilitate the development of trust. Because assessment procedures, depending on *how* they are used, can either interfere with or facilitate trust development, select specific procedures carefully and present them to clients in an open and honest manner.

Considerations of when, why, and how to administer formal assessments should be informed by graduate training in appraisal, test construction, and diagnosis. With regard to young people, it is especially important to note that formal assessment can have

a strong impact on the therapeutic relationship and often does not yield as much information as you might have hoped.

General Considerations for the Body of the Interview

When using play or physically interactive strategies with children, think through stated and/or unstated ground rules and be prepared to set limits that fit within your theoretical framework. In an assessment situation, the fewer rules, the better, as this allows the child more free expression. However, children often test limits. They try leaving the room, tinkering with items on your desk, opening windows, or even placing a call on your phone. More infrequently, they try mild aggression toward you: poking with a tack, spitting a spitball, swearing, and blowing smoke (literally). Rather than having stated rules covering all such potentials, it is better to be prepared to set firm limits as needed. Some theoretical orientations prefer to leave all rules unstated; others suggest the statement of one or two basic rules (Landreth & Lobaugh, 1998; Priestley & Pipe, 1997). The most common rule is usually stated something like this:

> "Billy, you're welcome to play with things in my office (or things from the toy closet). We don't have too many rules about playing here, but it's important that you know my one basic rule: It is not okay to break things or hurt yourself or anyone else with the toys or the art supplies."

Cleaning up and putting things away is also an assessment activity. It is challenging to keep time boundaries that include cleanup time before moving into the closing few minutes of the interview. Doing so provides information about how the child interacts when play is ending. An abrupt shift in attitude toward the toys or game may occur. The emotions directed at the toys may be an important signal about how the child feels about endings. In addition, note behaviors directed toward you. Does the child refuse to cooperate? Does he or she scurry around, cleaning frantically to impress you? Those few cleanup minutes at the session's end can be very revealing.

The following section describes tools and supplies helpful in working with children; Putting It in Practice 11.1 lists these supplies and suggests a group art assignment.

Arts and Crafts

Drawing is a favorite activity of many children and even a few adults (especially in the form of doodling through long boring meetings). All that is necessary are a few sharp pencils with good erasers, paper, and a nice flat solid surface. When interviewers invite children to draw, they often suggest a subject for the drawing. Kinetic family drawings, draw-a-person, and house-tree-person drawings are old favorites, but there is much to be gained from all sorts of drawings (Machover, 1949; Oster & Gould, 1987). More abstract and sometimes spontaneous assignments, such as "Draw me a quick sketch of how you feel about math" are sometimes quite informative.

When the child is busy drawing, the interviewer might wonder what to do. There is the option of drawing too, but it should be carefully considered. Children can get distracted and begin watching you, even comparing your work with theirs. This can provide meaningful information about the child, but can also become uncomfortable at times. Choice of subject, shape, size, and style of drawing by the interviewer can subsequently influence the child as well. Simply watching the child draw, or making a few supportive, nondirective comments or observations can often enrich the material gen-

Putting It in Practice 11.1

Art Therapy: Supplies and Practice

Art therapy is a specialized professional endeavor in which practitioners generally obtain master's level training. However, the use of art in working with young people does not require a degree in art therapy and can be rewarding for both you and your client. Most materials are neither complicated nor expensive. However, you should be familiar and comfortable with their use. Therefore, convince your graduate faculty or fellow graduate students to pool your resources and obtain the following:

- Colored chalk
- Watercolor paint sets
- A few basic color tubes of acrylic paint
- Some bottles of tempera paint
- Drawing pencils (or charcoal pencils)
- Colored pencils
- Fat markers and crayons
- Skinny markers and crayons
- Oil pastels
- Colored plasticine clay
- A big stack of nice white paper
- A roll of newsprint paper
- A big box of old magazines
- A few aprons
- Egg cartons for paint mixing
- Paintbrushes
- Good-quality paper towels
- Rags
- Chocolate (optional)

Right before finals is an excellent time for an experiential art party. Get a group together and do some expressive art. Pair up and reflect on the process with each other. Remember to be open, nondirective, and nonjudgmental—with yourself as well as with your partners. Ask indirect or open questions like "Tell me about your work" or "How did it feel to do this work?" or "What do you notice about your work?"

Treat each art piece respectfully. Notice the medium you chose. Clay is the "loosest"; colored pencils might be considered one of the more controlled choices (I. Rafferty, personal communication, June 8, 1998). In suggesting art as a modality to your client, you will be much more effective, insightful, relaxed, and convincing if you have recently used and played with art yourself.

erated by the drawing. Children often spontaneously explain core aspects of what stimulated their drawing choices.

Play-Doh is a familiar commodity in child therapists' offices. It provides a tactile, expressive modality and is considered fun by most children. Having a cleanable surface is essential. If your office is carpeted, a plastic tablecloth can solve some management problems. Play-Doh accoutrements include all sorts of molds and machines, but we prefer the more projective quality of letting the child create things free-form.

Clay (plasticine) is similar to Play-Doh but will not dry out and requires more working before becoming malleable. Clays that require firing are generally more difficult to use in controlled, meaningful ways unless the professional is quite familiar with this medium.

Painting is one of the more expressive modalities used in art therapies (Simonds, 1994; Thomson, 1989/1997). Although messier and harder to control than drawing, painting often elicits more emotion. Given the opportunity to work with tempera or watercolor paints, some children go from nonresponsive and uninvolved to happy, verbal, and very connected to the process.

Collage-building (using pictures or words) has become a favorite therapeutic use for old or unwanted magazines. Glue (or tape), scissors, magazines or picture calendars, and posterboard are the essential ingredients. You can ask clients to select pictures or phrases that help illustrate any number of things: life events, internal states, family troubles, school worries, and so on. They can attach their selections in any way they wish, sometimes creating an intense representation that would have been impossible to achieve with words.

CASE EXAMPLE

Kerry was a 12-year-old intellectually gifted boy struggling with an overcontrolling father and clinically depressed mother. He was born late in his parents' marriage; his mother was now 55 and his father was 61. His elderly grandparents on his mother's side lived in the family home. Both grandparents were frail and needed constant care, which was provided by Kerry's mother. Kerry was referred for individual counseling by his school counselor because his grades had slipped significantly, he was refusing to engage in his usual social activities, and he was making self-destructive comments in class. The interviewer invited Kerry to build a collage that illustrated his family life. Until that point, Kerry had, with his large, impressive vocabulary, indicated acceptance of his grandparents' needs and pride in his mother for caring for them. However, the collage was filled with pictures of young parents with little children and peppered with happy, upbeat words from advertisements. As the interviewer observed the contents, Kerry burst into tears and shared his longing for a "normal" family with young parents and happy, healthy grandparents. Although the therapist obviously couldn't change Kerry's family situation, the collage project provided a starting point for identifying and working through Kerry's grief and particular family needs.

Nondirective, Interactive, and Directive Play Options

"Children's play is both a result of their emerging ability to distinguish between appearance and reality and a causative factor in their further development of this important cognitive achievement" (J. Hughes & Baker, 1990, p. 46). For children, play is the stuff of life. It is the means by which they work out pain, achieve mastery, explore new

terrain, and take new risks. It is also a means by which they can distance themselves from things too difficult to deal with directly (Bateson, 1972).

Clinicians vary greatly in their use of play in working with children. Some prefer to model themselves after Virginia Axline, who advocated a nondirective, minimally interactive play therapy format, beautifully described in the book *Dibs* (Axline, 1964). Others use play and storytelling to enhance the therapeutic relationship and explore themes in the child's life (J. Sommers-Flanagan & Sommers-Flanagan, 1997). Still others find ways to use play and playful interactions to teach greater interpersonal empathy or more adaptive ways to behave (Brems, 1993; R. Gardner, 1971).

Not all interviewers have the luxury of a full set of potential play items. However, the following list of possibilities commonly used in child interviewing and therapy can be used to facilitate playful child-interviewer interactions.

Action figures is a category that includes such known and loved cultural icons as G.I. Joe, Ninja Turtles (which, according to our sources, are no longer considered cool *at all*), X-Men (and women), Pokemon, and Ken and Barbie. It also includes generic soldiers or Wild West figures. You do not need an elaborate or expensive collection; even a few "gray guys and green guys" are enough for children to create a sizable war or city or extended family if given the chance.

Sand trays come in all sizes and shapes. Working with a sand tray is a specialized skill that can become a central treatment modality (Thomson, 1989/1997). However, it can also be used simply for play or "fiddling around" while talking. Sand is a tantalizingly movable medium that many children can't resist. A good, sturdy lid and adequate floor covering is essential. You can collect items to play with, such as tractors, trucks, action figures, stones, and so on.

Stuffed animals are a comforting presence in a clinical office (Brems, 1993). Sometimes, child-oriented mental health professionals collect quite a set of stuffed animals. If more than one is present, children often create relationships among the animals. Varying the size and even collecting a whole family of stuffed bears enhance this likelihood.

Dress-up clothes are not as common as some of the categories in this list, but are easy to obtain for potential spontaneous use. A small suitcase of dress-up clothes can facilitate a breakthrough with an otherwise unresponsive child. Outfits such as cowpoke, firefighter, artist, plumber, and ballerina can easily be assembled. The suitcase itself can also elicit interesting play themes. It is amazing how young children can be powerfully drawn toward dress-up activities.

Construction sets vary in size, numbers of parts, and age-appropriateness. Lego, Lincoln Logs, and Tinker Toys are all helpful in engaging young clients in therapeutic activities. They should not be used with small children who might swallow them, and you should be wary of using them with children who have impulse control problems or violent histories. They can very easily become weapons.

Aggression items are a matter for consideration, but certainly provide vivid enactments with certain children. Your own values, professional training, and general background dictate your comfort level with toy guns, knives, swords, and other play weapons. They certainly allow for expression of aggressive urges. Some worry that they are too provocative and promote violent expression; others worry that having them in an office suggests a sort of approval of violence on the part of the counselor. These are issues for research and discussion in classes and with supervisors and colleagues as you determine what play items you are comfortable having in your office.

Dollhouses or other environments are classic props for allowing the child to reenact life dramas and traumas. The dollhouse is a time-honored play therapy tool. Many toy

companies now produce schoolhouses, gas stations, playgrounds, whole city blocks, and other plastic-molded environments complete with figures, vehicles, pets, furnishings, miniature toys, and so on. Children love the props these settings provide and often build entire communities of friends, enemies, and families. Themes emerging in the play are usually central for the child and provide many insights for an astute observer.

Anatomically accurate figures or dolls are common for particular kinds of interviews, but are not without controversy. For a short time, therapists who evaluated potential sexual abuse in small children were urged to use anatomically accurate dolls. If children then had the dolls interact sexually, this was interpreted quite concretely to indicate sexual exposure. Controversy quickly arose regarding the appropriateness of such interpretations (Koocher, Goodman, White, & Fredrick, 1996). Although anatomically accurate dolls still serve many useful functions, it is *essential* that the interviewer using them seek adequate training and supervision before doing so.

A final comment regarding collecting your toys: Be aware that you can inadvertently collect toys that reflect a certain cultural or socio-economic class exclusively. Find toys and dolls that are not overly expensive, that have different racial features, and are sturdy, inviting, and not easily broken.

Fantasy and Games

This category includes activities that require verbal interactions. They are described here because they do not involve direct interviewing procedures (e.g., questions and answers).

Storytelling procedures have captivated and/or influenced children for many centuries. Inviting the child to listen to a story, to make one up, or even to share the process back and forth can be entertaining and revealing (R. Gardner, 1971). There are many ways to use stories and storytelling activities (J. Sommers-Flanagan & Sommers-Flanagan, 1997). Very few materials are needed, but sometimes an active imagination is required. Lacking that, it may be helpful to have some favorite stories firmly memorized (see Putting It in Practice 11.2).

Acting or miming is a highly projective activity with children. Often, children love to make up a play and assign the acting parts. This activity can uncover themes of great importance in the child's life. Having the child write a script and then act it out can reveal things to both interviewer and child—especially as the child assumes the roles of the various characters in the play.

Familiar child games such as checkers and Candy Land, or card games such as Crazy Eights and Uno, can help break the ice and establish relationships with children. Assessment information can be obtained by observing the child's handling of setup, turn-taking, rule obedience, disappointing events, strategy, and eventual winning or losing.

Therapeutic games are available through a number of companies that serve mental health professionals' needs. They vary in their format, themes covered, appeal, and sophistication. It is worth obtaining a catalogue and checking out a few options, depending on the type of interviewing work you intend to do (see Suggested Readings and Resources).

Sometimes, children spontaneously generate an idea for a game. The level at which you choose to participate (if you participate at all) is a decision worth forethought. For example, one 7-year-old girl, referred because of social skill problems, decided it would be fun to play a form of hide and seek with a stuffed animal, a very fuzzy raccoon. Her inexperienced interviewer agreed and closed his eyes. The child climbed up the back of

Putting It in Practice 11.2

Storytelling

Some people believe that good storytellers are born, not made. We beg to differ. For this activity, you will need a partner and access to the creative side of your personality. If you're worried, try to reassure yourself by remembering that everyone has a creative side to their personality—even you.

Sit with a fellow student and start telling a story. You can tell any story you want. The only rules are that the story should have a beginning, a middle, and an ending. It also helps if the story includes some characters (e.g., people, Martians, ants) that have thoughts and feelings. The story can be about you, about animals, about spaceships, about anything. Simply start telling the story. Then stop telling it, while it is still incomplete, after about 30 to 60 seconds. At that point, the other person takes over telling the same story, using his or her unique storytelling style. Then, after about 30 to 60 seconds, switch storytelling authors again. The goal is to generate a story together with your partner or partners. The purpose is to loosen up your storytelling inhibitions, thereby allowing yourself to further develop your storytelling skills and talents. At the end of the story, you may provide one another with gentle interpretive statements (e.g., "I noticed Howard always brought conflict or tension back into the story, but Joyce seemed to always get everything resolved so that all the characters were feeling good again."). However, be sure to request permission before interpreting the meaning of anyone else's storyline. This activity will help prepare you for creative storytelling activities with young clients. You may also want to look at various storytelling resources (i.e., R. Gardner's *Mutual Storytelling Technique;* 1971; Chapter 5 of our *Tough Kids, Cool Counseling* book; see Suggested Readings and Resources).

the couch and placed the animal directly on the filament of a halogen lamp. The odor of burning polyester provided an excellent clue for helping the student interviewer locate the singed raccoon.

Creative ways and means to work effectively with children are abundant in the treatment literature (Brems, 1993; Priestly & Pipe, 1997). It is important to assess the needs, skills, and development level of the given child, the ramifications of the identified problem areas, your setting and its limitations, and your own exposure and comfort levels with the various tools listed.

THE CLOSING

Children experience time differently than adults. In fact, even the linear, nonreversible quality of time is not fully grasped by young children (Kovacs & Paulaukas, 1984). Therefore, telling a child there are 10 minutes left during a session may be less helpful than saying something more concrete, such as:

> "We just have a little bit of time left together. Probably enough time to read one more page (color one more picture, tell one more short story), and then I'll sum-

marize what we've talked about and see if I remember everything. Then we'll make a plan for next week, okay?"

As with adult interviews, you will probably always wish you could gather more information than you were able to get in 50 minutes. Unfortunately, you need to stop playing or gathering information and begin to wind down activities to ensure a smooth, unhurried closing with your child client.

Reassuring and Supporting Young Clients

Young people need support in their efforts to relate to you, so be sure to offer support throughout the interview. Especially during the closing, provide reassuring, supportive feedback. Make comments such as:

"You did some neat things with that Lego set."
"I know you told me this is your first time in counseling, but know what? You're pretty good at it."
"I appreciate all that you told me about your family and your teachers and you."
"Thanks for being so open and sharing so much about yourself with me."

Because most child clients do not come to therapy on their own, it is all the more important to let them know you appreciate them and the risks they have taken. Some young clients, especially challenging adolescents, may have behaved rudely or engaged in defensive, resistive actions. You might experience countertransference impulses such as urges to withdraw, reprimand, or even punish the child (Willock, 1986, 1987; J. Sommers-Flanagan, Sommers-Flanagan, & Palmer, 2001). It is certainly permissible to note the difficulty of being "dragged off to counseling" in an empathic comment and notice that the client seemed to have some reluctance about being open with you. However, as with adults, expressing anger or disappointment toward young clients who are resistant, defensive, or nondisclosing is inappropriate; such reactions make it less likely they will seek professional help again in the future. Instead, if your client is defensive, try to remain optimistic:

"I know it wasn't your idea to come in and talk with me today, and I don't blame you for being a little upset about it. We might be able to find some ways, together, to make this less of a pain. In fact, I might even know some ways that would make this whole thing go by pretty fast and then you'd be all done with counseling."

(For more information on termination strategies with difficult young clients, see "Termination as Motivation," in J. Sommers-Flanagan & Sommers-Flanagan, 1997.)

Summarizing, Clarifying, and Seeking Involvement

The most important closing tasks with young people are: (a) clearly summarizing your understanding of the problem areas; (b) making connections between the problems and possible counseling interventions (assuming you see such connections); (c) reminding the client about ways caretakers will or will not be involved; and (d) if possible, seeking some kind of positive involvement by the child. Two case examples follow. The first is an example of a 7-year-old struggling with nightmares. The second is an adolescent who repeatedly has been caught stealing from classmates.

CASE EXAMPLE 1: CLOSING

"So, Beth, our time is almost up. You've sure helped me understand what it's like for you trying to go to sleep at night. You get pretty frightened. Then everybody gets mad at you for not staying in bed. I think there are some things we can do to help you, but it'll mean coming back to talk some more . . . I hope that's okay with you. It also might mean having your mom and dad and big brother come in so I can talk with them about ways to help you. But you'll be here with me when I do that, and you and I will make a plan first. I'm thinking it would be good for us to see each other again in three days. Would that be okay with you? We might draw some more pictures, and I have a story I want to read to you. Do you have any questions before you go?"

CASE EXAMPLE 2: CLOSING

"Tommy, we've got a few minutes left together. I know this hasn't exactly been fun, but hey, you got out of English and a little bit of study hall, right? People are pretty upset with you for taking stuff—and even though you think you're borrowing stuff, it seems to be getting you in more trouble than it might be worth. I really appreciate the time you've taken to tell me what you think about all this and to answer all my questions about your family and stuff. I think we could work together to get things to chill out a little in your life. It wouldn't take too long because you're pretty smart about things, but at least a few more sessions to work together. I doubt if we need to involve your mom much, unless you get in more trouble. It can be just some planning and thinking between the two of us. You're pretty good at thinking about stuff. I bet we could come up with some ideas that would help. But I'd have to understand more about your life. It'll mean talking. Think you can stand coming back and talking with me a few more times?"

Empowering Young Clients

Because young people do not have final authority over many aspects of their lives, they usually respond well to being given choices and opportunities to ask questions. Leave time in your closing to shift the focus and allow the child time to ask questions and reflect on the process of being together with you:

"You know, I've done all the questioning here. I wonder if you have any questions of me?"
"Has our time together been like you thought it would be?"
"Is there anything about this meeting we've had that's bothering you?"
"Is there any last thing you want to say that I should have asked about?"
"I wonder if you felt there was anything I could have done in this interview that would have helped you feel more comfortable (or helped you talk more freely)?"

These queries help give the young client a sense of power and control. Although, as Foley and Sharf (1981) point out, it is important to maintain control toward the end of an interview, it is also important to share that control (carefully) with the child.

Tying Up Loose Ends

With young people, reconnecting with their parent or guardian is an essential piece of closure. Children are not able to arrange the details necessary to get themselves back to another session or follow through on recommendations resulting from the interview. Therefore, the interviewer must clear these things with the caretaker, preferably with the child present. Other related matters, such as fee payment and scheduling, can be addressed as well.

TERMINATION

The same general principles are true for children as for adults regarding conscious and unconscious termination concerns. It may be helpful for you to review the termination section in Chapter 6 as you prepare for a child interview. The main differences to anticipate are a matter of degree rather than substance. Children are often more overt and more extreme. An adult may *wish* to hug you but refrains, whereas a child may snuggle right up for a hug. An adult may fantasize telling you to "F___ off" toward the end of your time together, but an adolescent might just do it. Adults may feel a bit sad; children may burst into tears. Adults may register some disappointment; children may give you an ugly look, complain vociferously that their time is up, or even deliver a swift kick in the shin. They may even try refusing to leave or just announce they are tired of this and leave early. The interviewer needs to assume the role of observer, empathizer, and gentle limit-setter. Sometimes, children feel things, reflect things, and enact things quite acutely and dramatically. It is all part of the goodbye process.

SUMMARY

In many ways, interviewing children is qualitatively different from interviewing adults. This chapter identified basic differences between children and adults and discussed ways to professionally address these differences. In the introduction phase of the interview, the role of the child's caretaker must be considered and clarified. However, it is imperative for the interviewer to pay attention to the child, address him or her directly, and help him or her to understand the upcoming interview.

During the opening phase, if young clients are unable or unwilling to identify personal goals for therapy, we advocate using a procedure called *wishes and goals* to establish a positive tone, allow the child to engage in the process, and give parents a sense of being heard as well. With young clients, there are special issues in confidentiality that must be addressed. The child is a legal minor, and therefore, parents and guardians have certain rights to therapy information.

Obtaining assessment information during the body of a child interview is enhanced by the use of many nonverbal play tools and strategies. In addition, specific user-friendly assessment and information-gathering strategies should be used to assist the interviewer in obtaining information at the same time as developing rapport. When formal assessment instruments are used with young clients, their use should be explained to the client and assessment feedback should be provided.

Closing and termination procedures with children are similar to processes with adults, but they become more complicated for several reasons: There are more players to consider, more time demands to balance, and children may express their reactions to their interview experiences more overtly or bluntly than adults.

SUGGESTED READINGS AND RESOURCES

Brems, C. (1993). *A Comprehensive Guide to Child Psychotherapy.* Needham Heights, MA: Allyn & Bacon. This book includes important areas relevant to working with children: Legal and ethical issues, interview strategies, culture, environment, issues in assessment, various treatment modalities, and termination are all addressed.

Gardner, R. A. (1971). *Therapeutic storytelling with children: The mutual storytelling technique.* New York: Aronson. Gardner's book provides a good foundation for practitioners who like to use storytelling with their young clients.

Hibbs, E. D., & Jensen, P. S. (1996). *Psychosocial treatments for child and adolescent disorders.* Washington, DC: American Psychological Association. This edited volume strives to bring research and application together, considering both theory and environment in addressing common childhood disorders. Chapter foci include anxiety disorders, affective disorders, attention-deficit/hyperactive disorders, socially disruptive disorders, autistic disorders, and general treatment guidelines.

House, A. E. (2002). *The first session with children and adolescents.* New York: Guilford Press. This book will help you prepare for conducting initial interviews with young clients.

Hughes, J. N., & Baker, D. B. (1990) *The clinical child interview.* New York: Guilford Press. This text offers both theoretical and practical information for professionals engaged in assessing and treating children. It is applicable for school and agency settings.

Jongsma, A. E., Peterson, L. M., & McInnis, W. P. (2000). *The adolescent psychotherapy treatment planner.* New York: John Wiley & Sons. This treatment planning guide is set up in step-by-step fashion. It includes comprehensive coverage of most adolescent disorders and presenting problems and includes treatment goals and objectives as well as specific therapeutic interventions for each disorder.

Jongsma, A. E., Peterson, L. M., & McInnis, W. P. (2000). *The child psychotherapy treatment planner.* New York: John Wiley & Sons. This is another treatment planning guide designed for developing treatment plans for child clients. Similar to the preceding resource, it includes childhood disorders, presenting problems, treatment goals and objectives, and therapeutic interventions for each disorder.

Kelly, F. (1997). *The clinical interview of the adolescent: From assessment and formulation to treatment planning.* Springfield, IL: Charles C. Thomas. The process and procedures for interviewing difficult adolescents is described in this short book (216 pp.). It is a handy resource for students or professionals who work primarily with adolescent clients.

Richardson, B. (2001). *Working with challenging youth: Lessons learned along the way.* Philadelphia: Brunner-Routledge. Richardson offers over 50 "lessons" he has learned about providing counseling to difficult or challenging youth. Not only does it offer numerous practical ideas about counseling youth, but also this book is well-organized and written in a style that makes for pleasant reading.

Sommers-Flanagan, J., & Sommers-Flanagan, R. (1997). *Tough kids, cool counseling: User-friendly approaches with challenging youth.* Alexandria, VA: American Counseling Association. What can we say? This is just a magnificent book. Seriously, the book has a distinctly applied focus. The many suggested techniques and strategies have in common a goal of establishing and deepening the therapy relationship with young people who may not be relationship-oriented. The chapters on suicide and medication issues are especially practical and relevant.

Sommers-Flanagan, R., Elander, C. D., & Sommers-Flanagan, J. (2000). *Don't divorce us!: Kids' advice to divorcing parents.* Alexandria, VA: American Counseling Association. This book is based on interviews and surveys of individuals, both children and adults, who have experienced divorce firsthand. The book emphasizes the children's perspective and covers issues ranging from predivorce, parent-parent conflict during and after divorce, and new families.