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# **INVOLVING CHILDREN IN FAMILY THERAPY AND SYSTEMIC CONSULTATION**

## **ABSTRACT**

After reviewing the rationale for including children in therapy and reasons for the widespread practice of excluding them a variety of strategies for engaging children in various aspects of family therapy are described and illustrated with case examples. These include: making the therapeutic context attractive, explaining the therapeutic process and systemic ideas in concrete terms, tracking patterns of interaction using dolls and drawings, using genograms and lifelines to assess perception of family structure and development, using face drawings to assess perception of emotional atmosphere, tracking perceived changes using visual analogue scales, teaching turn taking, using personification and externalisation of problems and strengths to solve problems, reframing problems using stories and metaphors, coaching children in new skills and providing children with advocacy.

## **INTRODUCTION**

Family therapy has evolved into a modality largely suited to the articulate adult client with a facility for abstract reasoning. With some notable exceptions, family therapy takes scant account of the cognitive and linguistic developmental limitations of children (Ackerman, 1979; Bloch, 1976; Carpenter & Treacher, 1982, Dare & Lindsey, 1979; Satir, 1967; Keith & Whittaker, 1981; Wachtel, 1987; O'Brien & Loudon, 1985; Zilbach, 1986)).

This virtual exclusion of children from family therapy is common practice. In a major US survey Korner & Brown (1990) found that 40% of therapists excluded children from therapy sessions and 31% only included them in a token way. This is a serious problem.

## **WHY INCLUDE CHILDREN?**

Children need to be included in family therapy for seven main reasons. First, with child focused problems a useful evaluation of the nature and severity of the problem or the meaning of the problem for the child cannot be assessed without asking children for their view of the situation. This may occur either in the family session or in an adjunctive individual session. Obtaining the child's point of view is crucial during the assessment of high risk cases where depression, self-

harm, or abuse may be present (Carr et al, 1989). Second, children participate in patterns of interaction that surround presenting problems. If children are not present the therapist can neither observe these patterns nor ask children about their experience of these cycles of interaction and the beliefs that trap children within these patterns (Carr, 1990a).

Third, children often give more spontaneous and less guarded accounts of family problems. These both help the therapist's assessment and loosen constraints on adults within the family by drawing attention to unspoken issues. Metaphorically speaking, children can declare innocently that the emperor is not wearing any clothes. Fourth, children are often aware of emotional themes in family life which adults have repressed into the unconscious. When they speak about these in family therapy they open up new options and possibilities for solving family problems (Bloch, 1976). Fifth, children's ability to play: to deal with problems through the medium of drawings, toys, stories and games offer many avenues for bypassing adult defences and exploring new ways of resolving the presenting problem (Keith & Whittaker, 1981).

Sixth, direct (rather than indirect) coaching of parents in child-management skills or adolescent-negotiation skills is possible when children are included in therapy (Minuchin, 1974). Seventh, family sessions offer a forum where the therapist can facilitate the development of supportive relationships between parents and children.

### **WHY ARE CHILDREN EXCLUDED?**

Therapists exclude children from sessions for a variety of reasons. Many therapists feel poorly prepared by their training to work directly with children (Korner & Brown, 1990). Pre-adolescent children are difficult to engage in therapy because of their cognitive and linguistic immaturity. Before about the age of 12, children cannot easily be engaged in problem solving conversations involving abstract concepts. This is the type of conversation with which most therapists feel comfortable. Pre-adolescent children use enactments and images rather than abstractions and concepts to solve problems. Engaging them in activities and conversations about sensitive or complex matters using concrete images is very challenging.

Children can be difficult to involve in therapy because of their emotional state or behavioural characteristics. In the extreme children may be either obstinately silent and withdrawn or disruptive and aggressive. Therapists may fear losing professional credibility with parents if they try to include children in therapy and fail (Carpenter & Treacher, 1982).

Therapists may believe that the presenting difficulty is basically a marital problem expressed through the children and

therefore argue that the exclusion of the children is warranted on theoretical grounds. These beliefs may often be a rationalisation to defend against difficult emotions elicited by involving challenging children in therapy (Dare & Lindsey, 1979). Marital difficulties may co-occur with child problems (Frude, 1990). Good practice requires that separate therapeutic contracts be offered for each of these problems. The child problems cannot be ignored. Two ways are recommended for dealing with families that present with both marital and child problems. Whole family therapy may be followed by couples therapy after a resolution of the child's problem (Kniskern, 1981) or concurrent child and couples therapy may be offered (Kaslow and Racusin, 1990). Unfortunately no empirical research has been conducted to assess the relative efficacy of these practices.

#### **TECHNIQUES FOR INVOLVING CHILDREN IN FAMILY THERAPY**

A compendium of techniques drawn together from various sources over the past 15 years is presented below. Like most therapeutic techniques, none of those described here are completely new. However, the collection of the practices into a compendium and its presentation a solution to the problem of involving children in therapy is novel. The methods described here have been used with children between the ages of 3 and 12 in a number of contexts including an outpatient child and family centre in Ontario Canada; an NHS outpatient child and family centre, an NHS Paediatric ward in the UK; and private practices in the UK and Ireland. They have evolved within the context of an integrative approach to family therapy and systemic consultation (Carr, In Preparation). However, all of the techniques described below may be incorporated into the practice of most forms of family therapy.

### **MAKE THE PROCESS OF ATTENDING THERAPY SESSIONS ATTRACTIVE FOR CHILDREN**

Children find attending family therapy initially threatening (Carr et al, In Press). Their anxiety may be initially reduced by arranging a child oriented play area in the waiting room and by offering refreshments such as orange juice and biscuits. After each session children may be issued with stick on badges with smiling faces on them or other positive images. After a course of therapy children may be issued with a certificate to show that they have completed treatment.

### **EXPLAIN WHAT HAPPENS IN THERAPY IN CONCRETE TERMS**

Children's anxiety about therapy may be reduced by explaining in concrete terms the role they will be expected to play in therapy and what therapy will involve in concrete terms. This also helps them to contribute to the process more productively. In the following example the therapist explains the consultation process to a six year old with abdominal pain for which no physical basis could be found.

#### **Example 1.**

*Therapist:* You and I and your mum and dad are going to talk together in this room for about an hour or so. That's the same length of time as Sesame street is on. Do you watch Sesame street?

*Child:* Yes. Sometimes at granny's.

*Therapist:* Your mum and dad told me that they are worried about the pain yoke getting in your tummy. You know the one.

*Child:* (Nods.) mmmm

*Therapist:* Well I may be able to help you with that. OK.

*Child:* (Nods.) mmm (looks tearful)

*Therapist:* But the thing is this...I want you to know...You're at the doctor's. But there I don't give injections or use pills to make tummy aches better. So you needn't worry that I'm going to open up this drawer here (opens desk drawer) and take out a syringe and .....eh..give you an injection. You were worried about that maybe..?

*Child:* Yes. I don't like needles.

*Therapist:* But sometimes I ask people to do special exercises and things to help them get rid of aches and pains.

*Child:* What sort of exercises?

*Therapist:* The boy I saw this morning had to do some deep breathing exercises with his mum. That sort of thing. I'll see him again next week to check how he got on with the exercises. Do you do breathing exercises in PE.

*Child:* Sometimes.

*Therapist:* OK. So you know what I mean. Right ? But first I want you to draw a picture of yourself and show me where the pain is on the picture and what eh..colour it feels like..Ok....

### **EXPLAIN COMPLEX SYSTEMIC CONCEPTS USING CONCRETE MODELS**

Systemic concepts and the language used to express systemic ideas are complex. Nevertheless if children are to fully participate in therapy it may be important for them to understand some of these complex ideas such as the interdependence of family members, the cumulative effects of stress, and the effects of criticism and emotional overinvolvement (two of the main elements contributing to expressed emotion (Stubbe, 1993). These are best addressed through the use of concrete models (O'Brien & Loudon 1985).

***The Mobile.*** A fish mobile is a useful way to explain interdependence. Siblings of referred children, often ask why they have to attend therapy since they are not sick, sad or bad. I ask them to move one fish on the fish family mobile hanging in my office. Then I ask if the other fish were effected by this. This leads on to an exploration of how they are effected by their brother or sister having problems and how they can help with solving them.

***Balloons.*** Where youngsters are under pressure, they may be given a balloon to blow into the balloon once each time a stress factor that effects them is mentioned. The therapist then engages the rest of the family in an exploration of stresses that the youngster faces. Eventually the balloon bursts, dramatising the cumulative effects of the various stresses on the child. Where parents have difficulty empathising with the stresses a child faces this is a particularly valuable intervention.

***The Scales.*** Where parents criticise one child exclusively and ignore the shortcomings of the other children, a plastic balancing scales designed for teaching maths concepts is a useful way of dramatising the effects of this on the children. Each child can have a turn of using the scales while the therapist asks the parents about that child's daily behaviour. The child holding the scales must put one counter on the right side each time the parents say a positive remark and one counter on the left side for each critical comment. The unbalanced amount of criticism that the scapegoated child has to bear becomes evident and the need for balance in praise and criticism can then be explored.

***The Rope.*** Where a parent continually talks for a child, the child may be asked to hold one end of the rope and the parent to hold the other. Each time the child notices the parent talking for him, he has to pull the rope. This is a useful method for reducing enmeshment and emotional overinvolvement.

### **ASK ABOUT PATTERNS OF INTERACTION USING DOLLS, PUPPETS AND DRAWINGS**

Tracking sequences of interaction with children is a useful way of including them in therapy. Often children notice things in behavioural sequences to which adults will not admit or of which they are unaware. Important sequences are those in which the presenting problem is embedded and those exceptional patterns of interaction which are slightly different but where the problem does not occur. Comparing these sequences may then throw light on ways in which the problem may be resolved (Carr 1990a; 1990e). With young children these sequences may be dramatised using dolls or puppets or drawn on a whiteboard or flipchart. This helps children to keep whole sequences of interaction in memory when two or more sequences are being compared. This technique, adapted from play therapy, also allows children to express things that they may not be able to express in words (O'Connor, 1991).

### **DRAW A GENOGRAM AND FAMILY LIFELINE ON A WHITE BOARD**

The genogram and family lifeline, longstanding family evaluation methods, offer many opportunities for children to be involved in therapy particularly if these assessment methods are described as games. Drawing a genogram is a game the object of which is to draw a map of everyone in the family. The rules are that squares are for boys and circles for girls. Every circle or square must have a name and an age in it. And so on. The therapist can then ask questions of individual children or divide the family into teams with adults and children on each team and conduct a game show quiz. During the process of drawing a genogram gaps in family members knowledge and differences of opinion about family life may become apparent and require further inquiry. When the basic genogram is finished, more detailed information about key family members may be included and patterns identified (McGoldrick & Gerson, 1985; Carr et al, 1989)

A developmental family history can be represented pictorially on the whiteboard as a family lifeline. A game show quiz format may be used to involve the children in contributing to its construction. Gaps in knowledge and discrepancies between accounts may be explored when the lifeline is complete.

### **ASK CHILDREN ABOUT EMOTIONS USING HAPPY, SAD, SCARED AND ANGRY FACE DRAWINGS**

Draw faces representing these four emotions on a white board and ask the children in the family what emotions they represent. Then ask each

child one at a time to give their opinion about who is most sad, happy, scared and angry now. Follow this with questions about who is least sad, happy, scared and angry. Then inquire whether there has been a noticeable change in the way anyone has been feeling recently or since the onset of the problem. This will give a clear picture of how children experience the emotional climate of the family.

The children's understanding of the belief systems that family members hold can now be explored by asking questions about why each of the children think different people feel differently. For example a therapist may ask: Why do you think Mum is sad but Dad is angry?

### **TRACK CHANGES FROM SESSION TO SESSION USING VISUAL ANALOGUE SCALES OR BAR CHARTS DRAWN ON THE WHITE BOARD**

Tracking client's perception of change is a crucial aspect of therapy. Discussion of perceived change provides feedback necessary for developing more adaptive ways of coping. Visual techniques are particularly useful in helping young children describe and discuss their perception of changes in both the symptom and the family system.

Visual analogue scales are useful for helping children express perceived changes in the *intensity* of a problem or an emotion. They are particularly useful for detecting changes in pain, fear, anger, sadness and happiness. They can also be used to help children express changes in interpersonal factors such as how close children feel to their mother or how warm they feel about a family member. To use visual analogue scales meaningfully, anchor points must be agreed upon and held constant from session to session. Here is an example to illustrate the process.

#### **Example 2.**

*Therapist:* You see this line? It goes from 1 to 10. Now I want to know..eh..how ..eh sad or happy you've been feeling since last week. OK?

*Child:* Just ..a bit sad.

*Therapist:* OK. You said that last week so I'm going to ask you to use this line to help me see if you still feel the same or different. Worse or better. Now One stands for the sadness you felt when you had to go into hospital. Do you remember that feeling.

*Child:* Yes. I was really sad then.

*Therapist:* 10 is how you felt in Spain last year. Really happy. OK. 1 is sad in hospital and 10 is happy in Spain hospital. Got that.

*Child:* Yes.

*Therapist:* Put a mark on the line for how sad you are now.

*Child:* ...mmmm...here.

*Therapist:* Now put in a mark for how you felt last week. Better or worse than now.

Bar charts are useful to track changes in symptoms or events that can be expressed as *frequencies* such as the number of nightmares, the number of times a youngster vomited, the number of tantrums or the number of fires set. These are of most value if the parents keep an ongoing record of the events as they occur and then in each session the child can draw a bar chart for each week on the board and see the change in frequency herself.

The explicit tracking of symptoms and aspects of systemic functioning in a graphic way is common practice in many forms of cognitive and behavioural therapy (Gordon & Davidson, 1981)

### **TEACH TURN TAKING**

Silent children and disruptive children have difficulty participating in therapy. In both cases there is a need to introduce a concrete method for showing that it is the child's turn to speak. In Golding's *Lord of the Flies* in meetings of the council children were only allowed to speak if they held a large sea shell which symbolised authority: the conch. This practice is also useful in family therapy. The rules of turn taking need to be clearly spelled out. Everybody gets a turn. When it's their turn they hold the conch and speak. No-one can interrupt except the therapist if they speak for more than 4 minutes. When a person has finished talking they hand the conch back to the therapist who then passes it to the person whose turn it is next.

### **PERSONIFY AND EXTERNALISE PROBLEMS AND STRENGTHS**

Many psychological difficulties involve internal conflict. The person feels torn between two sets of feelings, beliefs or courses of action. An important part of therapy is to articulate the conflicting inner states and then explore alternatives for handling the dilemma. Children (and indeed many adults) find the process of externalising these competing inner states and naming them as people useful in managing this process.

**Example 3.** Theresa, a nine year old, was referred because she consistently failed to complete her homework despite staying up studying till after 10 pm. most evenings. She looked pale and tired during the intake interview. She said she wanted to finish her homework but the harder she tried to finish it, the less she got done. She was a very bright girl with an excellent academic record. Her difficulty was confusing for herself, her parents and her teachers. I asked her to write a brief essay

about her family in the session and tell me what she was thinking when she became stuck. With careful prompting she eventually identified how her need to improve each sentence she composed in her mind was preventing her from writing fluently. She externalized this urge by translating it into one half of a dialogue with the part of herself that wanted to write the essay. Here is part of the dialogue.

There are four people in my family.

No that's not quite right.

In my family there are my parents, my brother Paul and myself.

No that's the wrong way to start. What about the house.

My family lives in a bungalow in Malahide.....

I then invited her to personify this urge to re-edit everything she composed. She named the urge *Miss Right*. The goal of therapy became developing a relationship with *Miss Right* so that Theresa could ask her to go away and let her do her homework in peace and then come in afterwards and check that it was correct, rather than hovering over every sentence.

The externalisation and personification of urges to engage in problem behaviour is useful in obsessive-compulsive disorders, such as Theresa's, in phobias, with tics and with enuresis and encopresis. The key to working with urges to engage in negative behaviour is not to destroy this aspect of the self but to 'make friends with it' and integrate it into the child's sense of self.

Strengths and competencies can also be externalised and personified. Aggressive children who need to learn temper control or shy children who need to learn assertiveness may begin by externalising and personifying a character that has these new skills. The child can then be invited to let this character have a place in their life.

**Example 4.** Trevor, aged 10, was extremely shy and had difficulty making friends. However, he was a good cyclist. During therapy we developed a character called The Spin. The Spin was a brilliant cyclist and trickster who loved cycling with other people. However, he would only talk to people about bikes. No matter what you said to The Spin, he would always answer in terms of cycling. So if you said 'Hello', The Spin would say 'Hi, great day for wheelies.' If you said 'Goodbye', The Spin would say 'Bye, and hope you never get a puncture'. For home work I asked Trevor to cycle to the playground each day for gradually increasing periods of time and pretend to be The Spin. He found that when he did this he

was able to overcome his shyness. Eventually, he made two close friends. They talked a lot about bikes at first but later Trevor found that he talked about other things too. He no longer needed to pretend to be The Spin with his friends. However, he would bring The Spin back into his life whenever he felt threatened or shy.

Finally therapists can externalise and personify aspects of themselves that help engage children in therapy. Andrew Wood's (1988) co-therapist King Tiger is a delightful example of this approach. Andrew tells children that he will talk to King Tiger about their problems or strengths. King Tiger then writes the child a letter which Andrew delivers. The letters are all written from a child centred viewpoint and may be used to help the child reframe their situation, identify personal strengths, acknowledge accomplishments and so forth. The child is encouraged to write back to King Tiger and build a pen-friend relationship.

The processes of externalisation and personification are widely used in the psychotherapy field. The Gestalt Therapy empty chair technique is a common case in point (Yontef & Simkin, 1989).

#### **USE STORIES AND METAPHORS FOR REFRAMING**

The use of parables, myths and fairy tales to help people find solutions to problems of living is a custom that has its roots in the oral storytelling tradition. Within the family therapy field, Milton Erickson, is recognised as the key figure to integrate this ancient tradition into modern clinical practice (Haley, 1985). He and his many followers use therapeutic storytelling with both adults and children.

The key to good practice in this area is to take the salient elements of the client's situation and build them into a story which arrives at a conclusion that offers the client an avenue for productive change rather than a painful cul-de-sac. The story is a metaphor for the client's dilemma, a metaphor that offers a solution. This age old technique is particularly useful for involving children in therapy.

**Example 5.** Sabina, a 7 year old girl was referred because of recurrent nightmares in which she dreamt her house was being burgled and her parents assaulted. The nightmares followed an actual burglary of the family's shop, over which they lived. The girl dealt with the nightmares by climbing onto the end of her parents' bed so as not to wake them, trying to think of something else. During the day she refused to talk about the nightmares or the burglary. To some degree, her parents went along with this process of denial. Sabina was in the brownies and was learning about first aid when she was referred.

Towards the end of the first session I offered the following story.

Two brownies were on an adventure in the woods. They decided to have a race. They were both the same height and looked alike except that one had blond hair like yours and one had dark hair. While they were racing, and they were neck in neck all the way, they both tripped over the same branch and each of them cut their knee. The cuts hurt a lot and both girls felt like crying. The dark haired girl tried to stop herself from crying and her leg hurt more. The blond girl allowed herself to cry and felt relieved. The crying made her knee hurt less. Both girls went to the stream and bathed their cuts. Both girls had small first aid kits in their pockets. The dark haired girl put a bandage from her kit on her cut straight away. The blond girl could have done this also but she did not. She let her cut air. Both girls went home for tea. After tea they went to bed. The dark haired girl couldn't sleep because the cut hurt so much. She turned on the light. She took off the bandage and noticed that the cut had become infected. It was all yellow with puss. The dark haired girl washed the cut quickly and put on another bandage over the puss. The blond girl, woke in the middle of the night because her knee was hurting her. She woke her mum and her mum helped her bathe the cut in hot water to draw the puss out. This was painful, but she knew it would make her better. Three days later her cut was better. But her friend was still wearing a bandage. Her knee still had puss in it. She still woke up in the middle of the night with the pain.

In the conversation that followed, Sabina and her parents began to talk openly about the robbery and the nightmares and the parents spontaneously invited Sabina to wake them when she had nightmares. I asked Sabina to draw pictures of the nightmares and explain them to myself and her parents. After three sessions, over a period of a month, the nightmares had almost disappeared.

This story took account of Sabina's interest in first aid and racing. A physical trauma (cutting her knee) was used as a metaphor for the psychological trauma she had suffered (being burgled). The story included one course of action taken by the dark haired girl which resembled the pattern of coping she had adopted. It also contained an alternative. This other more adaptive route was taken by the blond girl. The girl whose hair was the same colours as Sabina's. This detail was included to make it easy for Sabina to identify with her. The story reframed Sabina's dilemma from 'How can I distract myself from memories of the robbery and get rid of these nightmares so I can feel

good.' to 'How can I squeeze all of this psychological puss out of my mind so the wound will heal?' This reframing offered a new avenue for coping.

### **ASK THE CHILD TO REHEARSE SKILLS NECESSARY FOR HOMEWORK IN THE SESSION**

Children delight in mastering new skills. This may be capitalised upon in family therapy by using sessions as a forum for teaching new skills that are to be practised as homework. Commonly these new skills will involve interacting with parents in particular ways.

Within the structural family therapy tradition Minuchin (1974) used to advise a peripheral father to spend special time with the problem child as homework but insist that the father and son begin planning the use of the special time in the session. If the father and son had poor communication skills, Minuchin would coach them in how to communicate more effectively.

With young children this coaching process can be applied to teaching children to play a variety of games or engage in a variety of activities with their parents, while avoiding unnecessary conflict. The skills include checking if the parent is available to play, planning an alternative time if the parent is unavailable, selecting a game, asking the parent to select a game, rule following, accepting interruptions without tantruming, accepting that the special time period is limited, showing appreciation and arranging to play again.

With young children behavioural parenting skills such as using time out or token systems can be taught with a high degree of child involvement if they are reframed as helping the child to learn self-control or self directed behaviour.

**Example 6.** Sean, a six year old, was referred because of tantrums and defiance. A time out and token system was developed with him and his parents in the following way. His temper was personified and externalized as Mister Fire. We spent some time talking about how hard it was for Sean to control Mr Fire and how useful it would be to be able to do so. It would help him to avoid rows with his parents. It would prevent him from feeling shame and in sports he could ask Mr Fire to help him to run fast and kick the football harder. At the close of this conversation Sean said he wished he could learn to control Mr Fire. I explained that any time Mr fire started coming out and making Sean be rude or naughty, he should run up to his room, let Mr fire have a good shout and then tell him to calm down. Sean agreed to do this. I said that he would need his mother's help some times. She could remind him to

bring Mr Fire upstairs or help him get Mr Fire back into the room if he escaped before he had calmed down. She agreed to this.

To tackle the problem of defiance, we first worked on Sean's refusal to tidy his toys up each evening. He loved to go to the adventure playground at weekends with his father, but this rarely happened. We discussed the playground at length and what incentives Dad might need to bring him there. After some prompting, Sean suggested that dad would love a Saturday Newspaper which cost 50p. The question then was, what chores could he do to earn this. A number were explored, and we settled on tidying the playroom each night at 6.00pm. Mum would pay him 10p if he completed the job successfully.

The parents kept routine behavioural records. The frequency of tantrums decreased rapidly after an initial increase and Sean regularly tidied the toys up for 6 weeks running. He also began to take responsibility in other areas.

In this example, the parents implemented routine behavioural time-out and token programmes (Gordon & Davidson, 1981). However, Sean participated in their development and implementation. He also construed them as an opportunity to learn how to control his temper and how to arrange to go the adventure playground with his father.

In paediatric settings children can be trained in the skills necessary to manage their own health and well-being. This is particularly important for children with chronic conditions like diabetes and asthma. Children need to understand their condition in terms that are age appropriate, be given a rationale for treatment that they can make sense of and be given very clear instructions and coaching in medical self care skills. In addition they need to be regularly monitored and their parents need to support and understand the child's self-care responsibilities. These guidelines are extrapolated from the extensive literature on compliance with medical advice (Carr, 1990d, 1990f).

**Example 7.** Pearse developed asthma as a young child and was admitted to the Paediatric ward on a number of occasions with severe attacks. To control his condition he was required to use a volumatic inhaler on a twice daily basis to take three actuations of Salbutamol (Ventolin) and Beclomethasone (Becotide). At the age of five he was trained in how to do this himself under parental supervision. It was first explained to him that the tight feeling in his chest and the difficulty drawing breath was because the little sponges in his lungs that soak up air were not working in the same way as a bike will cease up if you don't oil the chain. The inhalers were then presented as

special gases that uncease the little sponges in the lungs so that little bits of oxygen could get into the blood and make his muscles work so he could run and play. This led to a discussion about how the little bits of oxygen hitched a ride on the blood boats that travelled around the rivers of blood that flowed in the arteries and veins. We drew a diagram on the board and looked at a diagram in an anatomy atlas. We also discussed the consequences of not having enough oxygen. It would make him feel exhausted and unable to play. Once Pearse understood the rationale, he was eager to learn the very best way to use the inhaler. He was instructed in how to say "ready, steady, go" and use these mental self-instructions to co-ordinate the actuation with a deep intake of breath.

#### **PROVIDE CHILDREN WITH AN ADVOCATE**

In complex multiproblem cases, especially if there is multiagency involvement, there is a danger that the child's voice will become lost in the complexities of the problem determined system (Carr, 1990b, 1990c; Carr et al, 1989). This is often true of cases involving child abuse, foster care, parental criminality or psychiatric difficulties, bereavement, hospitalisation or special education. Providing the child with a key worker or advocate in such situations is an important way of ensuring that the child may participate in family therapy or broader systemic consultation meetings in a meaningful way. The advocate may involve the child in a series of individual sessions to help clarify the child's point of view. The advocate may then help the child present this view in family or network consultations.

**Example 8.** Cindy was originally referred for neuropsychological assessment and counselling by the Paediatrics Department in a District Hospital in the UK following a road traffic accident in which she sustained a closed head injury and in which her father was killed. Subsequently, her mother, Christine, a poorly controlled diabetic, had great difficulty caring for Cindy (aged 9) and her younger brother, Kevin, (aged 6). After a year, and a series of crises where Christine was unable to cope with the children, respite care was arranged with Social Services. Cindy and Kevin spent between 2 and 4 days a week with foster parents in a nearby village. This respite care evolved into full time care when Christine was hospitalised for surgery following the diagnosis of breast cancer. When Christine was discharged from hospital, an agreement was reached that the children

should stay in full time care, but that they would have regular visits with Christine, who felt unable to cope with them on a full time basis. In addition to the stress of bereavement, single parenthood, poorly controlled diabetes and cancer, Christine was also engaged in litigation for compensation in relation to the accident in which her husband was killed and her daughter injured. Throughout the five years I worked with this case, more than thirty professionals were involved. These included paediatricians, family doctors, school doctors, psychiatrists, nurses, occupational therapists, physiotherapists, social workers, remedial teachers, solicitors, barristers, foster parents, home aid workers and managers from the departments of Social Services and Education. Many of the systemic consultation meetings that were convened involved up to a dozen of these professionals along with Cindy, Kevin and Christine. A key element in involving both Cindy and Kevin in these consultations and allowing their opinions and views to be heard was providing them with advocacy throughout the process.

#### **DISCUSSION**

The approach to involving children in family therapy described here is based on three principles. First, at an ethical level children have a right to participate in the process of solving problems of living which they and their families face. Second, at a pragmatic level therapy has a better chance of success if those involved in the problem, including children, participate in the solution. Third, at a theoretical level, methods of engaging children in therapy must be based on an integration of both the therapeutic literature and the child development literature.

This approach to including children in therapy can be adopted by therapists from any professional background that includes a grounding in the basic therapeutic skills needed to engage children in a helping relationship. The skills outlined here can be refined in brief intensive training workshops. Of course, being a parent helps too, but its not essential.

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