FAMILY THERAPY AND INTELLECTUAL DISABILITY

by

Alan Carr

Biographical Note

Alan Carr, PhD. Dr Carr is the director of the Doctoral Training Programme in Clinical Psychology at University College Dublin and Consultant at the Clanwilliam Institute for Marital and Family Therapy in Dublin. His publications include The Handbook of Child and Adolescent Clinical Psychology: A Contextual Approach (Routledge, 1999), What Works for Children and Adolescents? A Critical Review of Psychological Interventions with Children, Adolescents and their Families (Routledge, 2000) and Family Therapy Concepts Process and Practice (Wiley,2000).
THE FAMILY LIFECYCLE

The family lifecycle is a useful framework within which to conceptualize the therapeutic needs of families containing children with intellectual disabilities. At transitional points within the lifecycle marked by events such as the birth of the child, entry into primary school, entry into secondary school, leaving secondary school and so forth, families face multiple stresses associated with having a child with a disability. They may, therefore, require episodes of intensive family therapy to help them manage the transitions between the stages of the lifecycle. So let us begin with a working definition of the family before sketching a widely used family lifecycle model.

With single-parenthood, divorce, separation and remarriage as common events, a narrow and traditional definition of the family is no longer useful (Walsh, 1993). It is more expedient to think of the child's family as a network of people in the child's immediate psychosocial field. This may include members of the child's household and others who, while not members of the household, play a significant role in the child's life. For example, a separated parent and spouse living elsewhere with whom the child has regular contact; foster parents who provide relief care periodically; a grandmother who provides informal day-care and so forth. In clinical practice the primary concern is the extent to which this network meets the child's developmental needs (Carr, 1999, 2000).

Having noted the limitations of a traditional model of the family structure, paradoxically, the most useful available models of the family lifecycle are based upon the norm of the traditional nuclear family with other family forms being conceptualized as deviations from this norm (Carter & McGoldrick, 1989). One such model is presented in Figures 1. This model delineates the main developmental tasks to be completed by the family at each stage of development. In the first two stages of family development, the principal concerns are with differentiating from the family of origin by completing school,
developing relationships outside the family, completing one's education and beginning a career. In the third stage, the principal tasks are those associated with selecting a partner and deciding to marry. In the fourth stage, the childless couple must develop routines for living together which are based on a realistic appraisal of the others strengths, weaknesses and idiosyncrasies.

In the fifth stage, the main task is for couples to adjust their roles as marital partners to make space for young children. This involves the development of parenting roles which entail routines for meeting children's needs for

- safety,
- care,
- control and
- intellectual stimulation.

Developing these routines is a complex process, particularly where couples have children with intellectual disabilities, and often difficulties in developing these routines leads to a referral for family therapy.

Routines for meeting children's needs for safety include protecting children from accidents by, for example, not leaving young children unsupervised and also developing skills for managing frustration and anger that the demands of parenting young children often elicit. Failure to develop such routines may lead to accidental injuries or child abuse.

Routines for providing children with food and shelter, attachment, empathy, understanding and emotional support need to be developed to meet children's needs for care in these various areas. Failure to develop such routines may lead to a variety of emotional difficulties.

Routines for setting clear rules and limits; for providing supervision to ensure that children conform to these expectations; and for offering appropriate rewards and sanctions
for rule following and rule violations meet children's need for control. Conduct problems or challenging behaviour may occur if such routines are not developed.

Parent-child play and communication routines for meeting children's needs for age appropriate intellectual stimulation also need to be developed, if the child is to maximize their potential in the areas of emotional, language and intellectual development.

For families with youngsters who have intellectual disabilities the transition into primary school is a major challenge, but essential for meeting the child's needs for intellectual stimulation. Negotiating a appropriate educational resourcing within the constraints of the available educational placement options and managing the impact of the transition to school on the child are major challenges that can tax the families coping resources to the limit.

In addition to developing parental roles and routines for meeting children's needs, a further task of this stage is for the parents' parents to develop grandparental roles and for the family as a whole to realign family relationships to facilitate this.

In the sixth stage, which is marked by children's entry into adolescence, parent-child relationships require realignment to allow adolescents to develop more autonomy. Managing this process when youngsters have intellectual disabilities can be particularly challenging for all family members. Good parent-child communication and joint problem-solving skills facilitate this process, and skills-deficits in these areas underpin many adolescent referrals for family therapy.

However, parents who find their families at this stage of development, must contend not only with changes in their relationships with their maturing children but also with the increased dependency of the grandparents upon them and also with a midlife re-evaluation of their marital relationship and career aspirations. The demands of
grandparental dependency and midlife re-evaluation may compromise parents' abilities to meet their adolescents' needs for the negotiation of increasing autonomy.

The seventh stage is concerned with the transition of young adult children out of the parental home. Ideally this transition entails the development of a less hierarchical relationship between parents and children. Securing appropriate accommodation with adequate supports for young adults with intellectual disability in a major challenge for families making the transition into this stage of the lifecycle.

During this stage, the parents are also faced with the task of adjusting to living as a couple again, to dealing with disabilities and death in their families of origin and of adjusting to the expansion of the family if their children marry and procreate.

In the final stage of this lifecycle model, the family must cope with the parent’s physiological decline, and approaching death, while at the same time developing routines for benefiting from the wisdom and experience of the elderly. This stage of the family lifecycle may be particularly challenging where parents have played a central role in supporting their adult offspring with intellectual disabilities. The question of how such parental support may be replaced as parents become unable to offer it, must be addressed.

**GRIEF PROCESSES AT LIFECYCLE TRANSITIONS**

Because most parents expect their children to be born without disabilities and to develop normally over the lifecycle, the birth and growth of a child with a disability may be accompanied by a sense of loss. That is, parents of children with intellectual disability may experience a sense of having lost the opportunity to bring up a child without such a disability. In this respect, parents of children with intellectual disabilities may be involved in a process of grieving. Initially, when parents are informed that their child has an intellectual
disability, the grief process may be set in motion. The grief process includes the sub-processes of shock; denial; yearning and searching, sadness and disappointment; anger; anxiety; guilt and bargaining; and acceptance. The way the news of disability is broken to parents affects their satisfaction with the consultation service received. The following factors are particularly important in breaking such news: the approachableness of the clinician, and the degree to which the clinician understands the parent’s concerns, the sympathy of the clinician, the directness and clarity of communication (Quine & Rutter, 1994).

Throughout the lifecycle at each transition, the family is reminded of the loss of the able-bodied child that was initially expected and the grief process recurs albeit in a progressively attenuated form (Goldberg, Magrill, Hale et al, 1995). Lifecycle transitions are particularly strong triggers for family grief processes, since they entail unique features when compared with lifecycle transitions associated with able-bodied children. For example the transition to school may entail a higher level of concern because of fears that the disability may prevent the child from forming peer relationships and fitting in. The leaving home transition may occur later in life, if at all. The impending death of the parents may be a particular source of anxiety, since a major concern may be who will care for the disabled child when the parent has died. An important process in family therapy is to help families both mourn their disappointments but also celebrate the achievements of their children with intellectual disabilities.

When parents of children with intellectual disabilities have difficulties coping with the demands of lifecycle transitions or other challenges posed by rearing a child with a disability, it is sometimes the case that the parent is experiencing adjustment problems arising from grief processes. Some such grief-related adjustment problems are listed in Figure 2. For example, parents involved in the grief process of denial may have difficulties
organizing appropriate supports and educational placements to meet the special needs of their children with intellectual disabilities. Or parents involved in the grief process of anger may have problems co-operating with multidisciplinary teams, and engage in unproductive conflict. Where grief-related adjustment problems, compromise their capacity to meet their youngsters special needs, family therapy may offer a forum within which to address these issues.

THE PROCESS OF FAMILY THERAPY

Family therapy is one way of helping families to cope with the additional challenges of the lifecycle entailed by having a youngster with an intellectual disability. The particular approach to family therapy outlined here is an integrative model which draws on ideas and practices from a variety of different traditions. A full account of the model is given elsewhere (Carr, 1995, 1997, 2000).

When working with families where a youngster has an intellectual disability, it is useful to conceptualize the process of family therapy as occurring in time-limited episodes, but within the overall context of an ongoing relationship between the family and the agency offering the therapy. At critical points in the family lifecycle, families may engage in episodes of therapy involving a limited number of sessions (e.g., 6 sessions) over a brief time period (e.g. 12 weeks). Much longer periods of time (e.g. a year) may elapse between these episodes of therapy, during which family therapy input is superfluous. Family therapy offers a forum within which the family is helped to solve specific problems (e.g., managing behaviour problems) or address specific issues (e.g., dealing with disappointment and loss). Often these problems or issues arise at transitional points in the family lifecycle.
Episodes of family therapy may be conceptualized as a series of stages using the framework, set out in Figure 3. In the first stage a plan for conducting the intake interview is made. The second stage is concerned with the processes of engagement, alliance building, assessment and formulation. In the third stage, the therapeutic contract, the completion of a therapy plan and the management of resistance are the primary issues addressed. In the final stage, disengagement or recontracting for a further episode of intervention occurs.

Within the context of this stage-based model of consultation, family therapy is usefully conceptualized as a developmental and recursive process. At each developmental stage, key tasks must be completed before progression to the next stage. Failure to complete the tasks of a given stage before progressing to the next stage may jeopardize the consultation process and lengthen treatment unnecessarily. For example, attempting to conduct an assessment without first contracting for assessment may lead to cooperation difficulties if the child or parents find the assessment procedures arduous.

Family therapy is an episodic and recursive process insofar as it is possible to move from the final stage of one episode of family therapy to the first stage of the next.

**STAGE 1. PLANNING**

In the first stage of family therapy the main tasks are to plan who to invite to the initial assessment session and what to ask them.

**Network analysis**

There is often confusion about who to invite to an intake interview in cases where youngsters with intellectual disabilities have multiple problems, are from multiproblem families, or are involved with multiple agencies. In these cases a network analysis may
be conducted. For network analysis, it is essential to find out from the referral letter or through telephone contact with the referrer who is involved with the problem and tentatively establish what roles they play with respect to it. With some cases this will be straightforward. For example, where parents are concerned about a child's enuresis, it may be sufficient to invite the child and the parents. In other cases, where school teachers, hostel staff or social services personnel are most concerned about the case, the decision about who to invite to the first interview is less straightforward. In these complex cases it is particularly important to analyze network roles accurately before deciding who to invite to the first session. Most network members fall into one or more of the following categories.

- The *referrer* to whom correspondence about the case should be sent
- The *customer* who is most concerned that the referral be made
- The *child* or children with the problem
- The legally responsible *guardians* who are usually the parents but may be a social worker or other representative of the state
- The primary *caregivers* who are usually the parents but may be foster parents, residential child care staff or nursing staff
- The child's main *teacher*
- The *social control agents* such as social workers or probation officers
- *Other involved professionals* including the family doctor, the pediatrician, the school nurse, the parent's psychiatrist etc.

Certain key network members constitute the minimum sufficient network necessary for effective case management (Carr, 1995). These include the customer, the legal guardians, the caregivers and the referred child. Ideally, all members of the minimum sufficient network should be invited to an intake meeting. If this is not
possible, then individual meetings or telephone calls may be used to connect with these key members of the network.

**Agenda planning**

In planning an agenda for a first family therapy meeting, a routine intake may be supplemented by questions which take account of the specific features of the case. The routine interview should cover the history of the presenting problems. This typically involves questions about the nature, frequency and intensity of the problems; previous successful and unsuccessful solutions to these problems; and different family members' views on the causes of these problems and possible solutions that they have tried or suspect may be fruitful to explore in future. In addition the intake interview should inquire about the child's individual physical, cognitive and psychosocial developmental history and an assessment of the family's development and functioning with particular reference to parent-child relationships; interparental relationships and the wider social network within which the family is embedded. Assessment of unique features of the case should be based on a preliminary formulation which contains hypotheses about possible antecedents, beliefs and consequences associated with the presenting problems. These hypotheses may be based on information given in the referral letter or phone call and the literature on the particular problem in question. For example, if a youngster presents with conduct problems or challenging behaviour, then important hypotheses to consider are that the possibility that the parent and child are engaged in a coercive cycle of interaction (Patterson, 1982). If a child, on the other hand, presents with social withdrawal at school, a hypotheses deserving consideration are that the child is experiencing anxiety because of some threatening event which occurred within the school.
STAGE 2. ASSESSMENT AND FORMULATION

Establishing a contract for assessment; working through the assessment agenda and recursively refining the preliminary formulation in the light of the information obtained; dealing with engagement problems; building a therapeutic alliance; and giving feedback are the more important features of the assessment and formulation stage which may span one or two sessions.

Contracting for assessment.

Contracting for assessment involves the therapist, the child or adolescent and significant network members clarifying expectations and reaching an agreement to work together. The first task is to explain what assessment involves and to offer the parents, the child and each relevant member of the network a chance to accept or reject the opportunity to complete the assessment. With children and teenagers, misconceptions need to be dispelled. For example, some children believed that when referred for therapy, they may be involuntarily admitted to hospital or placed in a detention centre. In some instances, children may not wish to complete the assessment, but their parents may be insistent. In others, parents may not wish to complete the assessment but a referring physician or social worker may forcefully recommend attendance. In such situations, the therapist may facilitate the negotiation of some compromise between parties. The contracting for assessment is complete when family members have been adequately informed about the process and have agreed to complete the assessment.

Recursive reformulation.
The assessment phase of the overall consultation process involves conducting interviews to check out the accuracy of the formulations and hypotheses made during the planning phase and modifying the formulations or hypotheses in the light of the information gained in the interview or testing sessions. In practice, the first round of interviewing may not only lead to a modification of the preliminary formulation but may raise further hypotheses that need to be checked out with further interviews or tests. The process comes to an end when a formulation has been constructed that fits with significant aspects of the child's problems; with network member's experiences of the child's problems; and with available knowledge about similar problems described in the literature. This formulation should inform the construction of a treatment plan. Building blocks for treatment plans are described below. A formulation is a mini-theory that explains the way in which particular situational antecedents; beliefs about these, the problem and related issues; and consequences for problematic behaviours maintain the presenting problem. A formulation may also highlight factors which predispose the child or adolescent to developing a particular presenting problem.

Here is an example of a formulation for a child with mild intellectual disability who presents with challenging behaviour. John is a 5 year old boy with a difficult temperament and this predisposes him to have difficulty with rule-following. In situations where he is tired, hungry or excited he has great difficulty following instructions from parents and teachers. He believes that such instructions are personal criticisms rather than requests for co-operative behaviour. At home and at school his parents and teachers typically respond to his unco-operative behaviour by either offering explanations and attention which positively reinforces his lack of co-operation or by withdrawing, which negatively reinforces his lack of co-operation by removing
what he perceives to be an aversive stimulus, i.e. instructions and directions for rule following.

**Alliance building**

In addition to providing information, the process of assessment also serves as a way for the therapist, the child, the parents and members of the network to build a working alliance. Building a strong working alliance with the child and key members of the child's family and network is essential for valid assessment and effective therapy. All other features of the consultation process should be subordinate to the working alliance, since without it, clients drop out of assessment and therapy or fail to make progress. The only exception to this rule is where the safety of child or family member is at risk and in such cases protection takes priority over alliance building. Key aspects of a therapeutic alliance include

- Warmth, empathy and genuineness should characterize the therapist's communication style
- The therapist should form a collaborative partnership with the family
- An invitational approach should be adopted in which family members are invited to participate in assessment and therapy procedures
- The inevitability of ambivalence about change becoming an issue within the therapeutic relationship should be acknowledged

The assessment is complete when the presenting problem and related difficulties are clarified; related antecedent situational factors, beliefs and consequences have been identified; a formulation has been constructed; possible goals have been identified; options for case management or treatment have been identified; and these have been discussed with the family.
**Feedback**

Giving feedback is a psychoeducational process. Children and their parents and siblings are given both general information about the type of problem they face (such as the degree of disability and additional problems such as ADHD or encopresis) and specific information about the way this relates to the formulation of their own presenting problems. Simplicity and realistic optimism are central to good psychoeducation. It is important not to overwhelm parents and children with information, so a good rule of thumb is to think about a case in complex terms but explain it to clients in as simple terms as possible. Put succinctly:

- *Think complex-Talk simple.*

Good clinical practice involves matching the amount of information given about the formulation and treatment plan to the client's readiness to understand and accept it. A second important rule of thumb is to engender a realistic level hope when giving feedback by focusing on strengths and protective factors first, and referring to etiological factors later. Put succinctly:

- *Create hope- Name strengths*

In providing psychoeducation about the general type of problem the family face, information on clinical features, predisposing, precipitating, maintaining and protective factors may be given along with the probable impact of the problem in the short and long term on cognition, emotions, behaviour, family adjustment, school adjustment and health.

The formulation is fed back to the family as a basis for a therapeutic contract. If the working alliance is the engine that drives the therapeutic process, the formulation is the map that provides guidance on what direction to take and what building blocks should be included in the therapy plan.
In some cases, the process of assessment and formulation releases family members' natural problem-solving skills and they resolve the problem themselves. For example, some parents, once they discuss their anxiety about handling their child in a productive way during a family assessment interview, feel released to do so.

**STAGE 3. THERAPY**

When parents and their children have completed the assessment stage, have accepted the formulation, and are aware of the broad therapeutic possibilities, it is appropriate to progress to the therapy stage. The central tasks of this stage are contracting for therapy to achieve specific goals; participating in the completion of the agreed therapy plan; and troubleshooting resistance. If at this stage, it is apparent that other family problems such as parental depression or marital discord require attention, referrals for this work may be made and it may be conducted concurrently with the child-focused family therapy programme. Alternatively, addressing these problems may be postponed until after the child-focused difficulties have been resolved.

**Contracting for therapy**

The contracting process involves inviting parents and their youngsters to make a commitment to pursue a specific therapeutic plan to reach specific goals. This plan may be constructed from one or more of the building blocks outlined below. Clear, realistic, visualized goals that are fully accepted by all family members and that are perceived to be moderately challenging are crucial for effective therapy. Goal setting takes time and patience. Different family members may have different priorities when it comes to goal setting and negotiation about this is essential. This negotiation must take account of the costs and benefits of each goal for each family member. It is
usually a more efficient use of time to agree on goals first, before discussing the details of how they might be achieved.

The contracting session is complete when all involved members of the child's network necessary for implementing the therapeutic plan agree to be involved in an episode of consultation to achieve specific goals.

**Therapy plans**

Family therapy plans are constructed from the following building blocks

- Psychoeducation
- Establishing supports.
- Redefinition
- Monitoring problems
- Communication training
- Problem solving training
- Supportive play
- Reward systems
- Behavioural control systems

The practices entailed by these building blocks will be detailed below with reference to examples.

**Psychoeducation**

The aim of psychoeducation in cases of intellectual disability is to help parents and other family members understand their child's diagnosis and its implications for the child's development and also to understand the nature and implications of formulations of secondary problems such as challenging behaviour, anxiety and so forth.
Psychoeducation is not a once-only event. It is an ongoing process. It begins with feedback after the first comprehensive assessment and recurs in subsequent meetings. When children are reassessed periodically, feedback from these assessments are further opportunities for psychoeducation.

It is very difficult for most parents to acknowledge and appreciate the implications of the diagnosis of intellectual disability when it is first mentioned, since the diagnosis violates their expectations associated with having a completely healthy child. Most parents experience shock and denial (two elements of the grief process described below). Clinicians on multidisciplinary teams have a responsibility to give parents and family members a clear, unified and unambiguous message about the diagnosis, since this is what the parents require to work through their denial and get on with the process of accepting their child's disability and dealing with it in a realistic way. The diagnosis should include information on the normative status of their child's cognitive abilities and adaptive skills; psychological and emotional status; biological factors; and supports necessary for the child to live a normal life. The way in which such supports may be accessed should also be clarified. These areas constitute the four axes of the diagnostic system developed by the American Association for Mental Retardation (AAMR, 1992). The main pitfall in psychoeducation is to give parents ambiguous information which allows them to maintain the erroneous belief that their child has no disability or a transient condition that will resolve with maturation. It is particularly valuable to offer psychoeducation within a family context, because it helps family members develop a shared perspective and belief system concerning the youngster's intellectual disability.

At periodic reviews over the course of the lifecycle, feedback sessions with parents and other family members are opportunities to continue the process of psychoeducation.
In these sessions, family members may be helped to develop accurate expectations concerning the strengths and limitations of the family member with intellectual disability.

Establishing support
Clinicians conducting family therapy may have a role in helping families to establish appropriate supports for themselves and their children with intellectual disabilities at various stages over the course of the family lifecycle. For good practice in this area, the child and family's support needs must be clearly stated in concrete terms; the precise action plans for arranging supports must be agreed with the family and the professional network; the precise roles and responsibilities of members of the professional network in providing supports must be agreed; the way in which the provision of supports will be resourced financially must be agreed; and the timetable of periodic review dates must be drawn up. Central to this type of system is the concept of a key worker who holds administrative responsibility for insuring the child's support plan is implemented. Even the most robust system of this type will flounder without an organizational structure which requires key workers to take responsibility for co-ordinating the implementation of support plans. The terminology used to describe these individualised support plans vary from country to country, but the principles of good practice, outlined in Figure 4, remain the same.

In family therapy sessions where the focus is on establishing supports, it is important to include both the family and other professionals who will be involved in providing support. Within these sessions create opportunities for everyone to make a contribution. When apparent disagreements occur between family members and professional, clarify both sides of the conflict, and acknowledge that different people have different views. This is far more productive than taking sides or trying to establish who is
right and who is wrong. When agreements about supports or schedules are reached write these down and arrange to send copies to all present. If the system of supports is not working, do not criticize family members or colleagues. This will only make future co-operation problematic. It is more effective to call another family-professional meeting and use this as an opportunity to solve the problems that prevent the system of supports from working.

**Redefinition**

Commonly the definitions that children and their families hold of the problems and related issues that prompt them to seek professional help are of limited value in helping them to resolve their difficulties. Redefinition of presenting problems and related issues is central to family therapy. Separating the problem from the person is one way to achieve this. Here the child's difficulties are defined as distinct from the child's identity and the child is described as being aligned with the parents and other network members in requiring a solution to the problem. Thus the child and parents may be described as a team who are working together to find a way to deal with a fiery temper, a difficult temperament, ADHD, anxiety, depression, encopresis, diabetes, addiction or whatever the problem happens to be. With young children, the problem may be externalized and personified and the child and family's task defined as defeating the personification of the problem. For example, obsessive compulsive disorder may be personified as *Mr Too-tidy*, enuresis may be personified as *Mr Wet-bed*. The parent's role becomes supporting the child in defeating Mr Wet-bed or Mr Too-Tidy.

**Monitoring problems**
For most difficulties, it is useful to train parents to regularly record information about the main presenting problems, their antecedents, consequences, related beliefs and impact of particular interventions. A monitoring chart for positive and negative target behaviours is given in Figure 5. This may be used where the central difficulty is a child or adolescent’s behaviour. For example, it may be useful for youngsters with conduct problems or sleep problems. When assessing a problem using this monitoring chart, events that typically precede and follow target behaviours are recorded in the second and fourth columns respectively. This information may suggest ways in which the frequency or intensity of negative target behaviours may be altered by inviting children and their parents to change the antecedent events that trigger problems or the consequences that reinforce them. The impact of these therapeutic interventions may be monitored using the same chart. Where the chart in Figure 5 is used to monitor positive target behaviours, it may throw light on the antecedent events that trigger these positive behaviours and the consequences that reinforce them and so suggest ways that the frequency of positive target behaviours might be increased.

**Communication skills**

Where parents and children have difficulties communicating clearly with each other about how best to manage the presenting problems, communication training may be appropriate. A common problem is that parents have difficulty listening to their children and children have difficulties clearly articulating their views to their parents. A second common communication problem is the difficulty parents have in listening to each others views about how best to manage the child's difficulties in a non-judgmental way. In some instances parents and children have never learned communication skills. In others, good communication skills have been acquired but intoxication or intense
emotions such as anger, anxiety or depression prevent parents and children from using these skills. Training in using communication skills is appropriate in the former situation but in the latter the key problem to be solved is how to arrange episodes of communication which will be uninfluenced by intoxication or negative mood states. Communication skills may be artificially subdivided into those used for listening and those used for telling somebody something. These skills are listed in Figure 6. Parents and children need, first, to be given an intellectual understanding of these skills. Then the therapist should model the skills for the clients. Clients should at this point be invited to try using the skills to discuss a neutral topic in the session. Let the episode of communication run for five or ten minutes, and take notes of various difficulties that occur. Then give feedback and, in the light of this, ask clients to complete the episode again. Typical mistakes include interrupting before the other person has finished, failing to summarize what the other person said accurately, attributing negative malicious intentions to the other person when they have not communicated that they hold such intentions, failing to check that the message was accurately sent, failing to check that the message has been accurately received, blaming and sulking. Once clients can use the skills to exchange views on a neutral topic, they may then be used to exchange views on emotionally loaded issues in the session first and later at home.

Communication homework assignments should be highly specific, to prevent clients from lapsing into poor communication habits. Thus, specific members of a family should be invited to find out the other person's views on a specific topic. A time and place free of distractions should be agreed and a time limit of no more than twenty minutes set for initial communication assignments.

**Problem-solving skills**
When it is apparent that parents or children need to take a more systematic approach to resolving problems, problem-solving skills training is appropriate. Joint problem-solving training for parents is useful where parents have difficulty co-operatively developing plans for solving children's difficulties. Joint problem-solving training for adolescents and parents may be useful where parents and teenagers are having difficulty negotiating about the youngster's increasing autonomy. Individual problem-solving training for youngsters may be helpful when children have specific peer group or academic problems that they repeatedly fail to solve, such as joining in peer activities without aggression or managing homework assignments set by their teachers. As with communication difficulties, clients may have difficulties solving problems because they lack the skills or because intoxication, negative mood states or other factors interfere with the use of well developed skills. Where such factors are present, therapy should focus on removing these obstacles to effective problem-solving. In problem-solving training, the sequence of stages described for communication training should be followed with a progression from explanation of the skills listed in Figure 7, to modeling, to rehearsal in the session with the focus on a neutral topic. Feedback should be given during rehearsal until the skills are well developed. Then clients may be invited to use the skills to solve emotionally laden problems. When families are observed trying to solve emotionally laden problems, often the first pitfall they slide into is that of problem definition. Many clients need to be coached in how to translate a big vague problem into a few small, specific problems. A second pitfall involves trying to solve more than one problem at a time. A third area of difficulty is helping clients to hold off on evaluating the pros and cons of any one solution until as many solutions as possible have been listed. This is important, since premature evaluating can stifle the production of creative solutions. Often families need
to be coached out of bad communication habits in problem-solving training such as negative mind reading where they attribute negative thoughts or feelings to others, blaming, sulking and abusing others. Where families with chronic problems successfully resolve a difficulty, a vital part of the coaching process is to help them celebrate this victory.

Supportive play

For children, particularly those with challenging behaviour, who have become embroiled in coercive problem maintaining interaction patterns with their parents, an important intervention is to train parents in providing their children with support. Parents may be coached in joint sessions with their children in how to do this. The guidelines for supportive play set out in Figure 8 are first explained. Next, the therapist models inviting the child to select a play activity and engaging in child-led play, while positively commenting on the child's activity, praising the child regularly and avoiding commands and teaching. Then the parent is invited to copy the therapist's activity and feedback is given to parents on what they are doing well and what they need to do more of. Finally, the parent and child are invited to complete a 20 minute daily episode of child-led play to increase the amount of support the child experiences from the parent.

Reward systems

Where the goal of treatment is to help children learn new habits such as complying with parental instructions, going to bed on time, taking medication, playing co-operatively with a sibling or coping with anxiety provoking situations, reward systems may be used. Guidelines for using rewards systems are presented in Figure 9. It is critical that the target behaviour is clearly defined, is monitored regularly, rewarded promptly, using a symbolic
system of points, tokens, stars or smiling faces that is age appropriate and acceptable to the child. An example of a smiling face chart is given in Figures 10. The symbolic reward system must be backed by tangible rewards or prizes which are highly valued, so that the child may buy these with points or tokens after they have accumulated a sufficient number. When points systems are ineffective, it may be that some adult in the child's environment such as a non-custodial parent in the case of children from separated families, is not committed to implementing the system. In other instances, the target behaviours may be ambiguous or the number of points required to win a prize too high. Trouble-shooting these difficulties is a routine part of coaching families in using reward systems.

**Behavioural control systems**

There are two common behavioural patterns that may maintain aggressive or self-injurious behaviour (Oliver, 1995). In the first pattern, a period of social isolation leads the child to a state of heightened need for social contact and challenging behaviour occurs. In response to this, the carer provides social contact until the child's need for contact is satiated. When the child's need for contact ceases, it is more likely that the child will engage in challenging behaviour again, since this has been positively reinforced by the carer's attention. It is also more likely that the carer will provide social contact in response to challenging behaviour, since giving attention leads the adult ultimately to experience relief (associated with negative reinforcement) when the challenging behaviour ceases. In the second pattern, the carer places demands upon the child and in response, the child engages in challenging behaviour which leads the adult to cease placing demands upon the child. When the episode ceases, the child is more likely in future to engage in challenging behaviour when demands are placed upon him, because in the past this has led to a
cessation of demands (negative reinforcement). The adult is more likely to stop making

- demands in response to challenging behaviour since this has led to a cessation of the
child's challenging behaviour (negative reinforcement). This pattern is discussed more fully
in the chapter on conduct disorders.

With both of these patterns, on the one hand the youngster needs to be coached in
developing more appropriate ways of communicating their needs to their carers and on the
other there is pressing need to help the youngster stop engaging in aggressive or self-
injurious behaviour as rapidly as possible. Reward systems described in the previous
section are useful in coaching youngsters to communicate their needs more effectively.

Behavioural control programmes, on the other hand are a rapid way of dealing with
aggression and self-injury. Guidelines for a behavioural control programme are set out in
Figure 11. The programme should be framed as a way for helping the child to develop
self-control skills. Specific negative or aggressive behaviours are defined as targets for
which time-out from reinforcement is given. When these behaviours occur, the parent
gives a command to the child to stop and this may be followed up by two warnings. If
children comply they are praised. If not they are brought to time-out without any display of
anger or any reasoned explanation being given at that time. The time for reasoned
explanation is at the outset of the programme or when it is being reviewed, not following
misbehaviour. During time-out, the child sits on a chair in the corner of the kitchen, the
hall or their bedroom away from family activities and interesting or reinforcing events or
toys. Following a period of two to five minutes (depending upon the child's age), the child
is invited to rejoin family activities and is engaged in a stimulating and rewarding exchange
with the parent. If children misbehave or protest aggressively while in time-out, they
remain there until they have been compliant and quiet for 30 seconds before rejoining
family activities and engaging in a stimulating interaction with the parent.
Running a behavioural control programme for the first two weeks is very stressful for most families. The normal pattern is for the time-out period to increase in length gradually and then eventually to begin to diminish. This pattern may be tracked using the time-out monitoring chart in Figure 12. During this escalation period when the child is testing out the parents resolve and having a last binge of self-indulgence before learning self-control, it is important to help families maintain the unconditionally supportive aspect of family life. There are two important interventions that may be useful here. First, spouses may be invited to set aside special time where the focus is on mutual marital support. Second, parents may plan episodes of supportive play with the children. The important feature of spouse support is that the couple set aside time to spend together without the children to talk to each other about issues unrelated to the children. In single parent families, parents may be helped to explore ways for obtaining support from their network of friends and members of the extended family.

**Troubleshooting resistance**

Accepting the inevitability of resistance and developing skills for managing it, is central to the effective practice of family therapy (Anderson & Stewart, 1983). Clients show resistance in a wide variety of ways. Resistance may take the form of not completing tasks between sessions, not attending sessions, or refusing to terminate the therapy process. It may also involve not co-operating during therapy sessions. For clients to make progress with the resolution of their difficulties the therapist must have some systematic way of dealing with resistance (Carr, 1995). First describe the discrepancy between what clients agreed to do and what they actually did. Second, ask about the difference between situations where they managed to follow through on an agreed course of action and those where they did not. Third, ask what they believed blocked
them from making progress. Fourth, ask if these blocks can be overcome. Fifth, ask about strategies for getting around the blocks. Sixth, ask about the pros and cons of these courses of action. Seventh, frame a therapeutic dilemma which outlines the costs of maintaining the status quo and the costs of circumventing the blocks.

When resistance is questioned, factors that underpin it are uncovered. In some instances unforeseen events - Acts of God - hinder progress. In others, the problem is that the clients lack the skills and abilities that underpin resistance. Where a poor therapy contract has been formed, resistance is usually due to a lack of commitment to the therapeutic process. Specific convictions which form part of clients' individual, family or culturally based belief systems may also contribute to resistance, where the clients values prevent them from following through on therapeutic tasks. The wish to avoid emotional pain is a further factor that commonly underpins resistance.

Questioning resistance is only helpful if a good therapeutic alliance has been built. If clients feel that they are being blamed for not making progress, then they will usually respond by pleading helplessness, blaming the therapist or someone else for the resistance, or distracting the focus of therapy away from the problem of resistance into less painful areas.

STAGE 4. DISENGAGING OR RECONTRACTING

The process of disengagement begins once improvement is noticed. The interval between sessions is increased at this point. The degree to which goals have been met is reviewed when the session contract is complete or before this, if improvement is obvious. If goals have been achieved, the family's beliefs about the permanence of this change is established. Then the therapist helps the family construct an understanding of the change process by reviewing with them the problem, the formulation, their
progress through the treatment programme and the concurrent improvement in the problem. Relapse management is also discussed (Marlatt & Gordon, 1985). Family members are helped to forecast the types of stressful situations in which relapses may occur; their probable negative reactions to relapses; and the ways in which they can use the lessons learned in therapy to cope with these relapses in a productive way. In brief CBT disengagement is constructed as an episodic event rather than as the end of a relationship. It is recognized that further episodes of brief CBT may be required in the future to address other specific problems. If goals are not reached, it is in the clients' best interests to avoid doing more of the same (Segal, 1991). Rather, therapeutic failures should be analyzed in a systematic way. The understanding that emerges from this is useful both for the clients and for the therapist. From the clients' perspective, they avoid becoming trapped in a consultation process that maintains rather than resolves the problem. From the therapists' viewpoint it provides a mechanism for coping with burnout that occurs when intervention fails to lead to therapeutic goal attainment.

REFERENCES


## Figure 1. Stages of the family lifecycle

<table>
<thead>
<tr>
<th>Stage</th>
<th>Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Family of origin experiences</td>
<td>• Maintaining relationships with parents, siblings and peers</td>
</tr>
<tr>
<td></td>
<td>• Completing school</td>
</tr>
<tr>
<td>2. Leaving home</td>
<td>• Differentiation of self from family of origin and developing adult</td>
</tr>
<tr>
<td></td>
<td>relationship with parents</td>
</tr>
<tr>
<td></td>
<td>• Developing intimate peer relationships</td>
</tr>
<tr>
<td></td>
<td>• Beginning a career</td>
</tr>
<tr>
<td>3. Premarriage stage</td>
<td>• Selecting partners</td>
</tr>
<tr>
<td></td>
<td>• Developing a relationship</td>
</tr>
<tr>
<td></td>
<td>• Deciding to marry</td>
</tr>
<tr>
<td>4. Childless couple stage</td>
<td>• Developing a way to live together based on reality rather than</td>
</tr>
<tr>
<td></td>
<td>mutual projection</td>
</tr>
<tr>
<td></td>
<td>• Realigning relationships with families of origin and peers to</td>
</tr>
<tr>
<td></td>
<td>include spouses</td>
</tr>
<tr>
<td>5. Family with young children</td>
<td>• Adjusting marital system to make space for children</td>
</tr>
<tr>
<td></td>
<td>• Adopting parenting roles</td>
</tr>
<tr>
<td></td>
<td>• Realigning relationships with families of origin to include</td>
</tr>
<tr>
<td></td>
<td>parenting and grandparenting roles</td>
</tr>
<tr>
<td></td>
<td>• Children developing peer relationships</td>
</tr>
<tr>
<td>6. Family with adolescents</td>
<td>• Adjusting parent-child relationships to allow adolescents more</td>
</tr>
<tr>
<td></td>
<td>autonomy</td>
</tr>
<tr>
<td></td>
<td>• Adjusting marital relationships to focus on midlife marital and</td>
</tr>
<tr>
<td></td>
<td>career issues</td>
</tr>
<tr>
<td></td>
<td>• Taking on responsibility of caring for families of origin</td>
</tr>
<tr>
<td>7. Launching children</td>
<td>• Resolving mid-life issues</td>
</tr>
<tr>
<td></td>
<td>• Negotiating adult to adult relationships with children</td>
</tr>
<tr>
<td></td>
<td>• Adjusting to living as a couple again</td>
</tr>
<tr>
<td></td>
<td>• Adjusting to including in-laws and grandchildren within the family</td>
</tr>
<tr>
<td></td>
<td>circle</td>
</tr>
<tr>
<td></td>
<td>• Dealing with disabilities and death in the family of origin</td>
</tr>
<tr>
<td>8. Later life</td>
<td>• Coping with physiological decline</td>
</tr>
<tr>
<td></td>
<td>• Adjusting to the children taking a more central role in family</td>
</tr>
<tr>
<td></td>
<td>maintenance</td>
</tr>
<tr>
<td></td>
<td>• Making room for the wisdom and experience of the elderly</td>
</tr>
<tr>
<td></td>
<td>• Dealing with loss of spouse and peers</td>
</tr>
<tr>
<td></td>
<td>• Preparation for death, life review and integration</td>
</tr>
</tbody>
</table>

Note: Adapted from Carter & McGoldrick (1989).
Figure 2. Adjustment problems arising from grief processes in parents of children with intellectual disability

<table>
<thead>
<tr>
<th>Grief Process</th>
<th>Underlying theme</th>
<th>Adjustment problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shock</td>
<td>• I am stunned by the loss of the child I expected to have</td>
<td>• Complete lack of affect and difficulty engaging emotionally with others</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Poor concentration</td>
</tr>
<tr>
<td>Denial</td>
<td>• My child has not got a disability or will grow out of his or her disability</td>
<td>• Not organizing appropriate supports and educational provision</td>
</tr>
<tr>
<td>Yearning and searching</td>
<td>• I will find a miracle cure and retrieve my 'normal child'</td>
<td>• Experimentation with alternative medicine or faith healing</td>
</tr>
<tr>
<td>Sadness and disappointment</td>
<td>• I am sad, hopeless and lonely because I have lost the child I wanted</td>
<td>• Persistent low mood, tearfulness, low energy and lack of activity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Appetite and sleep disruption</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Poor concentration</td>
</tr>
<tr>
<td>Anger</td>
<td>• I am angry because the child I needed has been taken from me</td>
<td>• Aggression</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Conflict with family members and professionals in health and education systems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Leaving the family</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Drug or alcohol abuse</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Poor concentration</td>
</tr>
<tr>
<td>Anxiety</td>
<td>• I am frightened that some threatening event will occur to me or my child</td>
<td>• Separation anxiety, agoraphobia and panic</td>
</tr>
<tr>
<td></td>
<td>because I have been so angry</td>
<td>• Somatic complaints, and hypochondriasis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Poor concentration</td>
</tr>
<tr>
<td>Guilt and bargaining</td>
<td>• It is my fault that my child has a disability so I deserve misfortune</td>
<td>• Self-harming behaviour</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Self-sacrificing behaviour</td>
</tr>
<tr>
<td>Acceptance</td>
<td>• I loved and lost the child I never had and now I must carry on without her</td>
<td>• Return to normal routines</td>
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<tr>
<td></td>
<td>while cherishing the disabled child that I do have</td>
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</tbody>
</table>
Figure 3. Stages of therapy

<table>
<thead>
<tr>
<th>STAGE 1</th>
<th>PLANNING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network analysis</td>
<td></td>
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<tr>
<td>Agenda planning</td>
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<table>
<thead>
<tr>
<th>STAGE 2</th>
<th>ASSESSMENT AND FORMULATION</th>
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<tr>
<td>Contracting for assessment</td>
<td></td>
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<tr>
<td>Recursive reformulation</td>
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<tr>
<td>Alliance building</td>
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<td>Feedback</td>
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<tr>
<th>STAGE 3</th>
<th>THERAPY</th>
</tr>
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<tr>
<td>Contracting for therapy</td>
<td></td>
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<tr>
<td>Completing the therapy plan</td>
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<tr>
<td>Troubleshooting resistance</td>
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<table>
<thead>
<tr>
<th>STAGE 4</th>
<th>DISENGAGEMENT OR RECONTRACTING</th>
</tr>
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<tbody>
<tr>
<td>Disengagement</td>
<td></td>
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<tr>
<td>Contracting for further work</td>
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<tr>
<td>Failure analysis</td>
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### Figure 4. Guidelines for establishing supports

<table>
<thead>
<tr>
<th>SPECIFIC GUIDELINES</th>
<th>GENERAL GUIDELINES</th>
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<tbody>
<tr>
<td>• Assess support needs in a systematic way using a system that fits with the cultures of the agency and the family</td>
<td>• Include the family and other professionals who will be involved in providing support in some or all family meetings</td>
</tr>
<tr>
<td>• State the child and family's support needs in concrete terms</td>
<td>• Create opportunities for everyone to make a contribution to the meeting</td>
</tr>
<tr>
<td>• Agree the precise action plans for arranging supports must with the family and the professional network</td>
<td>• When apparent disagreements occur between family members and professional, clarify both sides of the conflict, don’t take sides</td>
</tr>
<tr>
<td>• Agree the precise roles and responsibilities of members of the professional network in providing supports</td>
<td>• Write down agreements and timetables</td>
</tr>
<tr>
<td>• Agree the way in which the provision of supports will be resourced financially must</td>
<td>• If the system is not working, do not criticize the family or colleagues, call another family-professional meeting and solve the problems</td>
</tr>
<tr>
<td>• Draw up a timetable of periodic review dates</td>
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</tr>
<tr>
<td>• Follow through on the plan and review it for effectiveness</td>
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</tbody>
</table>
Figure 5. Chart for monitoring antecedents and consequences of positive and negative target behaviours.

<table>
<thead>
<tr>
<th>Day and time</th>
<th>What happened before the target?</th>
<th>What was the target behaviour and its intensity</th>
<th>What happened after the target behaviour?</th>
<th>What was the intensity of target behaviour after this consequence?</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td>1 = low</td>
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<td>1 = low</td>
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<td>10 = high</td>
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Figure 6. Guidelines for listening and communications skills

<table>
<thead>
<tr>
<th>SPECIFIC GUIDELINES</th>
<th>GENERAL GUIDELINES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LISTENING SKILLS</strong></td>
<td></td>
</tr>
<tr>
<td>• Listen without interruption</td>
<td></td>
</tr>
<tr>
<td>• Summarize key points</td>
<td></td>
</tr>
<tr>
<td>• Check that you have understood accurately</td>
<td></td>
</tr>
<tr>
<td>• Reply</td>
<td></td>
</tr>
<tr>
<td><strong>COMMUNICATION SKILLS</strong></td>
<td></td>
</tr>
<tr>
<td>• Decide on specific key points</td>
<td></td>
</tr>
<tr>
<td>• Organize them logically</td>
<td></td>
</tr>
<tr>
<td>• Say them clearly</td>
<td></td>
</tr>
<tr>
<td>• Check you have been understood</td>
<td></td>
</tr>
<tr>
<td>• Allow space for a reply</td>
<td></td>
</tr>
<tr>
<td>• Make a time and place for clear communication</td>
<td></td>
</tr>
<tr>
<td>• Remove distractions and turn off the TV</td>
<td></td>
</tr>
<tr>
<td>• Discuss one problem at a time</td>
<td></td>
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<tr>
<td>• Try to listen with the intention of accurately remembering what was said</td>
<td></td>
</tr>
<tr>
<td>• Try to listen without judging what is being said</td>
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</tr>
<tr>
<td>• Avoid negative mind-reading</td>
<td></td>
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<tr>
<td>• State your points without attacking the other person</td>
<td></td>
</tr>
<tr>
<td>• Avoid blaming, sulking or abusing</td>
<td></td>
</tr>
<tr>
<td>• Avoid interruptions</td>
<td></td>
</tr>
<tr>
<td>• Take turns fairly</td>
<td></td>
</tr>
<tr>
<td>• Be brief</td>
<td></td>
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<tr>
<td>• Make congruent “I” statements</td>
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</tbody>
</table>
Figure 7. Guidelines for problem-solving skills

<table>
<thead>
<tr>
<th>SPECIFIC GUIDELINES</th>
<th>GENERAL GUIDELINES</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Define the problem</td>
<td>• Make a time and place for clear communication</td>
</tr>
<tr>
<td>• Brainstorm options</td>
<td>• Remove distractions and turn off the TV</td>
</tr>
<tr>
<td>• Explore pros and cons</td>
<td>• Discuss one problem at a time</td>
</tr>
<tr>
<td>• Agree on a joint action plan</td>
<td>• Divide one big problem into a few small problems</td>
</tr>
<tr>
<td>• Implement the plan</td>
<td>• Tackle problems one at a time</td>
</tr>
<tr>
<td>• Review progress</td>
<td>• Avoid vague problem definitions</td>
</tr>
<tr>
<td>• Revise the original plan</td>
<td>• Define problems briefly</td>
</tr>
<tr>
<td></td>
<td>• Show that the problem (not the person) makes you feel</td>
</tr>
<tr>
<td></td>
<td>bad</td>
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<tr>
<td></td>
<td>• Acknowledge your share of the responsibility in</td>
</tr>
<tr>
<td></td>
<td>causing the problem</td>
</tr>
<tr>
<td></td>
<td>• Do not explore pros and cons until you have</td>
</tr>
<tr>
<td></td>
<td>finished brainstorming</td>
</tr>
<tr>
<td></td>
<td>• Celebrate success</td>
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</tbody>
</table>
Figure 8. Guidelines for supportive play

<table>
<thead>
<tr>
<th>SPECIFIC GUIDELINES</th>
<th>GENERAL GUIDELINES</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Set a specific time for 20 minutes supportive play per day</td>
<td>• Set out to use the episode to build a positive relationship with your child</td>
</tr>
<tr>
<td>• Ask child to decide what he or she wants to do</td>
<td>• Try to use the episode to give your child the message that they are in control of what happens and that you like being with them</td>
</tr>
<tr>
<td>• Agree on an activity</td>
<td>• Try to foresee rule-breaking and prevent it from happening or ignore it</td>
</tr>
<tr>
<td>• Participate wholeheartedly</td>
<td>• Avoid using commands, instructions or teaching</td>
</tr>
<tr>
<td>• Run a commentary on what the child is doing or saying, to show your child that you are paying attention to what they find interesting</td>
<td>• Notice how much you enjoy being with your child</td>
</tr>
<tr>
<td>• Make congruent <em>I like it when you</em>... statements, to show your child you feel good about being there</td>
<td></td>
</tr>
<tr>
<td>• Praise your child repeatedly</td>
<td></td>
</tr>
<tr>
<td>• Laugh and make physical contact through hugs or rough and tumble</td>
<td></td>
</tr>
<tr>
<td>• Finish the episode by summarizing what you did together and how much you enjoyed it</td>
<td></td>
</tr>
</tbody>
</table>
### Figure 9. Guidelines for reward systems

<table>
<thead>
<tr>
<th>SPECIFIC GUIDELINES</th>
<th>GENERAL GUIDELINES</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Define the target behaviour clearly</td>
<td>• Present the reward system to your child as a way of helping him or her learn</td>
</tr>
<tr>
<td>• Decide when and where the monitoring will occur</td>
<td>grown-up habits</td>
</tr>
<tr>
<td>• Make up a smiling-face chart or points chart</td>
<td>• All parental figures in the child's network should understand and agree to using</td>
</tr>
<tr>
<td>• Explain to the child that they can win points or smiling faces by carrying out</td>
<td>the system</td>
</tr>
<tr>
<td>the target behaviour</td>
<td>• Use a chart that is age-appropriate. Smiling faces or stars are good for</td>
</tr>
<tr>
<td>• Ask the child to list a set of prizes that they would like to be able to buy with</td>
<td>children and points may be used for adolescents</td>
</tr>
<tr>
<td>their points or smiling faces</td>
<td>• The sooner points are given after completing the target behaviour, the quicker</td>
</tr>
<tr>
<td>• Agree on how many points or faces are necessary to buy each prize</td>
<td>the child will learn</td>
</tr>
<tr>
<td>• Follow through on the plan and review it for effectiveness</td>
<td>• Highly valued prizes lead to faster learning</td>
</tr>
<tr>
<td></td>
<td>• Try to fine tune the system so that successes are maximized</td>
</tr>
<tr>
<td></td>
<td>• If prizes are not being won, make the target behaviour smaller and clearer or</td>
</tr>
<tr>
<td></td>
<td>the cost of prizes lower and make sure that all parent figures understand and</td>
</tr>
<tr>
<td></td>
<td>are committed to using the system</td>
</tr>
<tr>
<td></td>
<td>• If the system is not working, do not criticize the child</td>
</tr>
<tr>
<td></td>
<td>• Always keep the number of target behaviours below 5</td>
</tr>
</tbody>
</table>
Figure 10. Child’s star chart for child reward systems

<table>
<thead>
<tr>
<th>Time</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><img src="image1.png" alt="Smiley" /></td>
<td><img src="image2.png" alt="Smiley" /></td>
<td><img src="image3.png" alt="Smiley" /></td>
<td><img src="image4.png" alt="Smiley" /></td>
<td><img src="image5.png" alt="Smiley" /></td>
<td><img src="image6.png" alt="Smiley" /></td>
<td><img src="image7.png" alt="Smiley" /></td>
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**Figure 11. Guidelines for behaviour-control programmes**

<table>
<thead>
<tr>
<th>SPECIFIC GUIDELINES</th>
<th>GENERAL GUIDELINES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BEHAVIOUR CONTROL PROGRAMME</strong></td>
<td>• Set out with the expectation that you can teach your child one good habit at a time</td>
</tr>
<tr>
<td>- Agree on a few clear rules</td>
<td>• Build in episodes of unconditional special time into behavioural control programme</td>
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<tr>
<td>- Set clear consequences</td>
<td>• Frame the programme as learning self-control</td>
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<tr>
<td>- Follow through</td>
<td>• Involve the child in filling in, designing and using the monitoring chart or system</td>
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<tr>
<td>- Reward good behaviour</td>
<td>• Monitor increases in positive behaviour as well as decreases in negative behaviour</td>
</tr>
<tr>
<td>- Use time-out or loss of privileges for rule breaking</td>
<td>• Do not hold grudges after episodes of negative behaviour</td>
</tr>
<tr>
<td>- Monitor change visibly</td>
<td>• Avoid negative mind reading</td>
</tr>
<tr>
<td><strong>TIME-OUT</strong></td>
<td>• Avoid blaming, sulking or abusing</td>
</tr>
<tr>
<td>- Give two warnings</td>
<td>• Ask for spouse support when you feel bad about the programme</td>
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<tr>
<td>- Bring the child to time-out without negative emotion</td>
<td>• Celebrate success</td>
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<tr>
<td>- After five minutes engage the child in a positive activity and praise him for temper control</td>
<td>• If rule-breaking continues, return child to time-out until thirty seconds of quietness occurs</td>
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<tr>
<td>- Engage in positive activity with child and praise for temper control</td>
<td>• Build in episodes of unconditional special time into behavioural control programme</td>
</tr>
</tbody>
</table>

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*Child and Adolescent Problems*
Figure 12. Time-out monitoring chart

<table>
<thead>
<tr>
<th>Date</th>
<th>Time going in</th>
<th>Number of minutes in Time Out</th>
<th>Situation that led to time out</th>
<th>Pleasant activity that happened afterwards</th>
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