1995

Application of the relational model of therapy in cross cultural counseling with children

Nancy L. Wolfe

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APPLICATION OF THE RELATIONAL MODEL OF THERAPY  
IN CROSS CULTURAL COUNSELING WITH CHILDREN

A Thesis
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the
Master of Science
in
Psychology

by
Nancy L. Wolfe
June 1995
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Approved by:

Edward Teyber, Ph.D. Chair, Psychology
Faith McClure, Ph.D.
David Chavez, Ph.D.
ABSTRACT

The purpose of this study was to examine the origins of the Multicultural Relational Model of therapy and demonstrate the application of this model in the clinical setting. Subjects were two ethnic minority children, a Hispanic boy, age nine, and a mixed-race boy, age 10, who was adopted by an African American family. One subject presented with Separation Anxiety Disorder, while the other presented with symptoms of Conduct Disorder. In these case studies, the therapists vividly demonstrate how the Multicultural Relational Model blends the best from the etic, emic, and interpersonal process models. Therapists in the past, who have identified themselves as "multicultural" or "relational", may have worked in ways similar to the Multicultural Relational Model, however, the similarities and ways in which each enriched the other has not been clearly articulated. These case studies articulate exactly how the "multicultural" and "relational" have been blended to enable positive therapy outcomes.
ACKNOWLEDGMENTS

I wish to thank Dr. Teyber, a genuine and caring human being who has worked as my teacher, advisor, mentor, and emotional support through this process. I also wish to thank Dr. Faith Mc Clure for her kindness, friendship, direction, and rich intellectual contribution. I thank both Dr. Teyber and Dr. Mc Clure for sharing with me their vast knowledge, skills, and their own precious world views. This sharing has enriched my life. It is this unselfish experience of sharing who we are as human beings, that I hope to share with my own clients as I provide therapy in the coming years. Both Faith and Ed have both been inspirational to me in my life.

I also wish to thank Dr. David Chavez. He gave me a chance to assist him with research as an undergraduate. He supported me in my effort to pursue my interest in clinical psychology. He collaborated with me in the writing of the case study of Brian, a long and tedious process. He supported me in my effort to enable this thesis to evolve in it's present form. I am grateful for the many things that he had helped me to accomplish in my academic career at California State University, San Bernardino.

I want to thank Dr. Stuart Ellins for inspiring my renewed interest in psychology as I first began my studies at this university. When I had returned to college, I had planned to go into education. After taking my first class in Behavior Modification with Dr. Ellins, I became so curious about psychology
again, that my direction changed. His precise systematic teaching style has given me inspiration as I hope to continue to teach psychology in the future and as I teach my clients. I have also been impressed by his ability to foster my own initiative and self respect, by the respect he had for me. These are the qualities that have promoted my own growth, and are qualities that I hope to emulate as I continue my work with people.

Finally, I want to thank the friends and family that have supported me in this quest. Thanks to Noreen Jaster and Belisario Ventura for their objective feedback, honesty, humor, emotional support, and friendship. I thank my husband Hans van der Touw, for his patience, financial support, and encouragement through this journey full of sacrifice. I thank my wonderful mother that nurtured my love of learning as a small child, and for her endless love and support throughout my life and as I accomplish this academic goal. She has been invaluable to me as a role model and as an example of a person who is passionate about living, learning, and loving other human beings. Lastly, I would like to thank my father who passed away before winter quarter this year. I would like to thank him for his belief in me, and for the way he taught me to be strong and tenacious in a life that is not always easy. I would like to thank him for his love, respect, and for his ability to provide that secure base that I needed to flourish in my life. I hope that he is somewhere sharing my success.
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Introduction

The practice of psychotherapy as means of relieving psychological distress in western culture was first developed and practiced by European and European American theorists and practitioners. One of these early psychologists, Wilhelm Wundt, began to study of cross cultural psychology as far back as 1879 (Jahoda, 1989). The earliest empirical studies of cross cultural psychology date back to the work of Rivers at the beginning of this century in 1901 (Ongel & Smith, 1994). In the formative years of therapy, however, the application of therapy was traditionally reserved for a select population and did not explicitly take into consideration the influence of cross cultural factors. Like their therapists, the first therapy clients were also usually European or European American, and treatment models were often designed according to "universal" theories of human behavior. That is, models and approaches were well developed and applied similarly to all clients with little or no attention to how the client's cultural characteristics (e.g. race, religion socio-economic status,) might impact these applications. Additionally, therapy in it's early years targeted a select socioeconomic group, since it was primarily reserved for members of the upper class who could afford to sponsor the cost of treatment and who had the luxury of time demanded for the lengthy treatment model.

In more recently decades, however, the models and the role of therapy has gradually changed. Therapy, as a method for helping people to cope with
psychological problems, has become a widely accepted treatment approach. Therapists not only work in private practices but also hold positions in schools, hospitals, prisons, and numerous specialty clinics. The acceptance of psychotherapy and recognition of its value is evident in the fact that it has now become part of benefit packages made available by managed health care facilities, universities, employment firms and a part of government sponsored treatment agencies. With this growing acceptance, training programs for clinicians have become widespread, enabling the cost of therapy to be reduced and allowing the availability of therapy to reach a wide variety of people with diverse cultural and economic backgrounds.

As a result of these changes, clinicians have come to acknowledge that the therapy model which fit the clientele of the first founding therapists, may not fit the diverse populations of the modern therapist. For example, in this decade in the United States, the ethnic minority population has grown to represent 24% of the total population (U.S. Bureau of the Census, 1990). Thus many therapists today are working with clients of various ethnic and cultural backgrounds, life experiences, genders, and ages. These multicultural factors make each client, without exception, unique. That is, each client develops a worldview that is specific to their individual, familial, and cultural experiences and differs from that of other clients and the therapist.

Clinical interventions with individuals presenting with socio-cultural differences have traditionally been dealt with by the use of one of two different
theoretical approaches. These terms, coined by Pike in 1967, are the etic and emic approaches to cross-cultural counseling. This paper will examine both advantages and limitations of the etic and emic approaches and will propose a Multicultural Relational Model which attempts to blend the two approaches into a single, comprehensive, and integrative therapeutic approach designed for the treatment of children. Following the discussion of the etic, emic, and Multicultural Relational Approaches, the new Multicultural Relational Approach, will be illustrated by two extensive case studies of children presenting with 1) a common internal disorder (Separation Anxiety Disorder) and 2) a common externalized childhood disorder (Conduct Disorder). These two case studies will illustrate how in these particular cases, the relevant cultural features were conceptualized and the Multicultural Relational Approach was used to incorporate the specific cultural features in each of these cases, in order to optimize the treatment effectiveness.

Etic Approach

Of the two traditional approaches to cross cultural counseling, the etic school of thought seeks to compare different cultures in order to produce species specific generalizations about human behavior (Berry, 1989). Pike (1967) suggests that this approach views human behavior from outside the system, as the objective observer, focusing on commonalities. Pike suggests that this should be the initial approach to examination of any unfamiliar system. In terms of therapy application, in the etic approach to therapy, the
therapist minimizes the differences between different individual world views and assumes universal application of therapy theory and techniques (Sue & Sue, 1990). Proponents of this theory suggest that by emphasis of commonalities rather than differences, they are able to maintain a humanistic link between different subgroups of society and their common struggle as members of humanity in general. There have been humanist and existential theorists who have gone so far to suggest that only through this connection as individuals to our common experience of humanness, can we develop an effective therapy relationship (Vontress, 1979, Draguns, 1989, Fukuyama, 1990).

Theoretical opponents on the other hand, have contended that the etic approach fails to acknowledge and adjust for the fact that culture imposes qualitatively different effects on the experiences and development of the individual. Many have suggested that the comparatively higher therapy drop-out rates for minorities [50%] compared to Whites [30%] (Sue & Zane, 1987), may be attributed to the traditional western therapy approach, which has not taken into account these salient cultural differences. They propose that the overgeneralized, etic approach may lead to inappropriate conceptualizations, ineffective interventions because of incongruence with cultural values, inability to appreciate the client's own subjective culture, and consequently high rates of premature termination for minority clients.

**Emic Approach**

According to Pike's early definition (1967), the emic viewpoint examines
human behavior from inside a specific system, focusing on the unique properties of the system being examined compared to the larger system. In the emic approach to counseling, the therapist focuses on the variables which are culture specific. Counseling techniques and methods of intervention are designed specifically for the culture of the client. This ethnographic approach has been utilized by important theorists in the field of therapy for minority groups in general, and specifically in the treatment techniques for adolescents and children. Huang and Gibbs (1989) use this ethnographic approach in a highly respected text specifically designed for the counseling teens and children. The authors delineate specific characteristics which influence the counseling process for an array of ethnic groups. In this approach, cross-cultural researchers acknowledged that individual differences exist within a cultural group but they stress the importance of ethnographic factors. That is, that there are differences between groups based on culture, coupled with similarities among individuals within particular ethnic and racial minorities.

Sue and Sue (1990) are influential emic theorists who propose that the language, values, and life experiences, which shape world view and self-identity, are all culture bound. Furthermore, these cultural variables do not remain constant across cultural, ethnic and racial sub-populations, therefore emic theorists propose that it is necessary that the clinician have knowledge about each group specifically, in order to effectively make normative comparisons, create culturally sensitive interventions, and fully understand the
client's world view in the context of their culture. The primary criticism of this therapy approach is derived from the danger that the inexperienced therapist or rigid therapist who thinks in terms of categories rather than individuals may use this culture specific information to form stereotypes which may wash out relevant information about individual client differences (Mc Clure & Teyber, 1996, in press).

Integration of Etic and Emic Approaches

The etic and emic schools of thought in the last couple of decades have been dichotomized, leading to philosophical division among psychological theorists and clinicians alike. Pike (1967) had suggested early in this theoretical debate however, that both the etic and emic approaches are valuable approaches and that neither has superior value over the other, both being necessary (Berry, 1989). More recent theorists have suggested that the ideal therapy approaches should blend these two perspectives.

Pedersen (1991) proposed that multiculturalism be conceptualized as the "fourth force" in therapy theories, complementing psychodynamic, behavioral, and humanistic approaches for explaining human behavior. He further proposed that the multicultural perspective be seen throughout the field of counseling as relevant in a generic way rather than in an exotic way. Pedersen's call for acceptance of the multicultural model, as a necessary element affecting all therapy, was a critical move toward blending the etic and emic approaches theoretically. Pedersen affirmed the need for cultural
sensitivity including knowledge of culture specific factors while integrating attention to universal human commonalities and the importance of specific individual differences. Additionally, Pedersen (1991) expanded the concept of culture to include such factors as demographic characteristics (including age, sex, place of residence), status variables (educational & socioeconomic), affiliations, nationality, ethnicity, language, and religion as well as the traditional cross-cultural focus on values, beliefs and behaviors unique to the group being studied. Lacking in this expanded concept of multicultural counseling however, was a practical framework to aid in the application of multicultural sensitive theory to therapy process and outcome.

**The Relational Approach**

The Relational Model provides the framework necessary to support and apply multicultural theory. The Relational Model has its foundation in the attachment theory, object's relations theory and the social dimensions of cognitive behaviorism which have all stressed the importance of the interaction or "process" that occurs between the client and therapist (Bowlby, 1988; Kahn, 1991; Kiesler & VanDenberg, 1993; Klerman et al., 1984; Teyber, 1992). Many theorists believe that it is the quality of the therapist/client relationship that provides the corrective emotional experience that can lead to psychological healing. Elements of the therapeutic relationship which enable this healing to occur include the therapist's ability to provide the client with accurate empathy, active listening, compassion and warmth, focused attentiveness, and emotional
availability (McClure & Teyber, 1996, in press). Strupp (1989), in a review of the therapy outcome literature, has concluded that these variables which are associated with positive therapy outcome are also the variables related to the quality of the therapeutic relationship.

According to McClure & Teyber (1996, in press), the interpersonal therapist systematically utilizes the relationship to guide treatment. This process necessitates that the therapist identify the client's problematic relational patterns as part of the client conceptualization. These patterns can be witnessed in the play of the child client, in the relationships the child has with family members and the relationship the child has with the therapist. For example, the little boy who has a history of being transferred from one foster home to another may anticipate that all interpersonal relationships never last long, and that to become attached to another person only means more intense pain upon separation. This child may stay aloof and distant for protection. He may refrain from engaging the therapist in play with him. He may be oppositional with caretakers. Treatment would require that the therapist determine 1) what is wrong for the child; 2) what is needed for change in the child's current relationships with others; and 3) use the therapeutic relationship as the context for specific interventions that change maladaptive relational patterns in the current interaction between the therapist and the client.

McClure and Teyber (1996, in press) further describe that the therapist's goal is to provide a corrective solution to the child's conflicts in the
here-and-now relationship of the client and therapist. The child's core or "generic conflicts" are hypothesized to color the client's relational perceptions and patterns, influencing all relationships, including the one the client maintains with the therapist. The therapist's intent is to use her or his experience of the client to identify these problematic relational patterns. The therapist works together with the client to identify how these patterns are played out in the therapy relationship and with others. The therapist's primary goal is to provide an emotionally more satisfying interpersonal response to the client than the response that the child has typically been receiving from parents and others. Others in the life of the child often have had limited capacity or have been unable to respond in a manner which meets the child's needs, and the new, different, and more satisfying response provides a solution to the child's relational need. This process has historically also entailed helping the client to understand how individual and family factors have contributed to the client's personal and relational problems and the interpersonal coping styles children have developed. The therapist and the client collaborate in an attempt to understand and alter the malfunctional relational patterns.

This "better response" has been conceptualized by several theorist and termed in various ways. Alexander (1963) suggested the term "corrective emotional experience". Bandura (1977) posed that the therapist structures opportunities for "enactive mastery". Weiss and Sampson (1986) spoke of the therapist's goal of disconfirming of "pathogenic beliefs". Kiesler (1986) coined
the phrase "challenge to change" while Andrews (1991b) termed this process "interpersonal challenge." All terms suggest that in the context of the therapy relationship, the therapist is able to give a new and different response to the old problem, which allows the client to emotionally heal and develop a wider interpersonal range. The case studies which follow will demonstrate the therapist's ability to provide such a corrective response to the child client. The change is facilitated not by an explanation of what needs to change but by the experience of change in the child's current interaction with the therapist.

Multicultural Relational Approach

Although in the past therapists who identified themselves as "multicultural" or "relational" worked in similar ways with clients, the similarities and ways in which each conceptual frame enriched the other was not clearly articulated. According to McClure and Teyber (1996, in press), both endorse the value of the treatment process to treatment outcome. If the manner in which the therapist conceptualizes the client, the therapy process, or treatment goals are culturally incongruent, the client's "generic conflicts" are likely to be re-enacted in the therapeutic relationship or simply result in treatment that is less effective. When this occurs, treatment is unable to provide the necessary corrective relational response and premature termination is more likely to occur. Thus, both approaches respect the influence that culture can have on the development of these unresolved conflicts.

Both multicultural and relational approaches also emphasize the need for
the therapist's own personal awareness. The therapist must objectively understand the factors that contribute to their own unique, subjective world view as well as that of the client. McClure and Teyber (1996, in press) suggest that these worldviews include personal assumptions, biases, thoughts, and feelings. They note that both approaches appreciate the fact that this worldview has been shaped by factors such as race, ethnicity, gender, familial experience, and socio-political influences, which strongly influence the process and outcome of therapy. Further, both multicultural and relational approaches share the concept that socio-cultural and interpersonal variables significantly affect development, emotional health, and pathology. The approaches also share a sensitivity to the unique quality of the client's individual history, unconditional acceptance of the dynamics that the client brings to the therapy relationship, and the a continuing attempt to individualize the therapy process and join with the client in the current conflict with the ultimate goal of providing a more satisfying solution. This treatment approach, now termed Multicultural Relational to signify the compatibility between them, emphasizes the impact of cultural factors beyond the individual and family factors typically taken into account and explicates how and interpersonal process approach provides the best framework for it's application.

Method

This thesis proposes to provide a demonstration of how the Multicultural Relational Therapy Model is applied in the context of the therapeutic
relationship. Two case studies will provide two extensive illustrations of how the relational and multicultural model are blended to provide culturally sensitive, individualized treatment.

Subjects

The clients in this project or illustration include two young boys, Henry age 9 and Brian, age 10. Henry, a Hispanic boy whose mother is from Guatemala and whose father is from Mexico, presents with Separation Anxiety Disorder. Brian, a mixed-race child adopted by an African American family presents with Conduct Disorder.

Procedure

In each of the two cases, the two therapists will demonstrate vividly how they are provide an emotionally safe and accepting environment in which the client can test maladaptive assumptions that are generated by historic generic conflicts. Both cases will illustrate how the therapist is able to generate responses which are different than those the children have experienced with parents and others, and facilitate change as the therapists help these young clients generalize this emotional re-workings beyond the therapeutic relationship. These "better" responses however, are only made possible through the therapist's ability to empathically understand how individual differences, unique experiences, familial influences, socioeconomic factors, religious beliefs, age, gender, ethnicity, and culture all blend together to create the client's distinctive worldview. It is only with this complex understanding, that
the therapist can design an intervention which provides an emotionally corrective experience, enabling the client to resolve longstanding conflicts. This "corrective emotional experience" occurs when the therapist responds in a manner that is different than the responses that have occurred in significant relationships in the past, providing a new and different experience. It is only through this process, that the therapist is able to facilitate the client's ability to better function in more satisfying relationships and improve emotional wellbeing.

ILLUSTRATION I - Case Study of Henry

Authors: Anthony Zamudio, Ph.D, and Nancy Wolfe, M.S.

General Introduction:

In the course of human development, what an infant learns about the nature of his environment is initially defined by his/her relationships with primary caretakers. The primary caregiver's sensitive reading, and prompt response to the infant's needs is crucial in the development of a secure attachment, and instrumental in the portrayal of the world as a place in which the child's needs can be met. The attachment figures provide the child with a "secure base," communicating to the child that they are reliably available to help the child feel secure while exploring and mastering his/her environment. If the mother models power and confidence in her negotiation of the world, and communicates her belief that the child too is capable of such mastery, the child can come to share that perspective. Given this world view, and given confidence about the continuing availability of the caregiver, the child will feel
safe to explore this exciting new environment.

In normal development, however, the infant's great joy in developing a secure bond with the caregiver also goes hand in hand with anguish over fear of losing her. As very young children develop into toddlers, they begin to master this separation anxiety in several ways. Through increasing cognitive and affective abilities, the young child becomes better able to hold the image of the caregiver in mind, and to experience her loving feelings toward the child, during her absence. The ability to crawl, walk and talk also seems to counteract the child's sense of helplessness at her departure, and to foster the child's initiative and expanding interests in others and the world-at-large. When normal development goes awry, however, some older children "regress" to this panic over separation and develop Separation Anxiety Disorder (SAD) at some phase between the preschool-school and adolescent years. Rather than approaching the world with curiosity and confidence, these children remain dependent and cannot separate from caretakers. Thus, the core characteristic that defines SAD is excessive anxiety about separation from parents and other attachment figures. When there are no demands to separate, the child is not symptomatic; similarly, when the attachment figure returns, the child's distress is relieved. Let's look more closely at the symptoms that SAD children present.

When their attachment figures are about to leave, younger children with Separation Anxiety Disorder may shadow or cling to their parents; and cry, plead or have temper tantrums in order to make them stay. Reactions to
impending separations can be so intense that children may wish they were
dead, threaten suicide, vomit, or have panic attacks (young children's inability to
explain their symptoms clearly makes diagnosis of a panic disorder difficult).
Children with SAD also have nightmares, exaggerated fears of animals and
monsters in the dark, and often refuse to sleep alone. Somatic complaints may
include headaches, nausea and stomach aches for younger children, while
older children may have cardiovascular symptoms such as palpitations,
dizziness and faintness. Older children with SAD organize their lives around
avoiding potential separation experiences. Often they cannot go to camp or
spend the night away with a friend without feeling distressed, homesick or
yearning for reunion. Some may not even be able to go on simple errands by
themselves. Of particular importance, as many as three-fourths of SAD
children may refuse to attend school in order to be near the attachment figure.
Although there may be some concern about harm to themselves when
separated from caregivers, the essential concern for SAD children is the worry
that some accident, illness or harm will befall the caregiver while they are away.
In order to make a diagnosis of SAD, DSM-IV (APA, 1994) indicates that
anxiety over separation must be beyond developmental or expectational norms
(which will vary greatly across cultures), last for four weeks or more, begin
before age 18, and impair or disturb important areas of the child's functioning
(e.g., ability to attend school). SAD is a common disturbance - prevalence
estimates are about four percent in children and adolescents. It is one of the
few disorders with equal incidence for boys and girls in clinical studies, although more frequently in females in epidemiological studies. Average age of onset is nine years, although it can occur anytime between preschool-school and adolescence. Anxiety about potential separation and avoidance of situations involving separations (e.g., going away to college or the military) may wax and wane at different points in development, but the disorder may persist for many years.

SAD is routinely co-morbid with other disorders - especially depression. When social withdrawal results in depression, an additional diagnosis of Dysthymic Disorder or Major Depression may be justified. Child therapists also need to differentiate SAD from other similar or overlapping disorders - especially School Phobia. Some children refuse to go to school because they are afraid of aversive experiences at school, such as being ridiculed by peers or failing academically. Although SAD and School Phobia often overlap, fear of something in the school setting or associated with the school is the defining symptom for school phobic children. In contrast, children with SAD are afraid of separating from the mother or attachment figure - usually because of the fear that some harm will befall her in the child's absence. Children diagnosed as SAD also tend to be younger, female, from lower SES families, and to have more symptoms and Axis 1 disorders than school phobic children, whose overall functioning is much better ((Last, Francis, Hersen, Kazdin, and Strauss, 1987a).
SAD also must be differentiated from Panic Disorder. In SAD, the anxiety symptoms concern separation from home and attachment figures (which may escalate to panic levels), whereas in Panic Disorder, the symptoms result from concerns about being incapacitated by the possibility of having an unexpected panic attack. At times, SAD in younger children will precede the development of Panic Disorder with Agoraphobia following puberty (APA, 1994). Adults diagnosed with Panic Disorder and Agoraphobia had an earlier onset if they had met the criteria for SAD in childhood (Gruppo Italiano Disturbi d'Ansia, 1989). Additionally, Agoraphobia spectrum avoidance has more sudden onset and severe symptomology when the subject had a history of SAD or School Phobia (Perugi et al., 1988). SAD may precede other Psychosomatic Disorders as well (Sperling, 1982). Finally, it is important to emphasize that even though SAD children often are demanding and manipulative, they are not malingering or attention-getting like truant or conduct disordered children. SAD children are genuinely afraid of separation and their anxiety is alleviated only when the attachment figure returns.

Researchers do not yet fully understand the etiology of SAD. There may be a genetic component as it is more common in first degree relatives and in children of mothers with affective disorders (especially Depression) and Panic Disorder with Agoraphobia. One study revealed that 83% of mothers with children diagnosed with SAD or Overanxious Disorder had a history of anxiety disorders themselves. Additionally, 57% of the mothers presented with Anxiety
Disorders while their children were seen for similar problems (Last, Hersen, Kazdin, Francis and Grubb, 1987b). Another study revealed that mothers of children with SAD were found to be four times more likely to have an affective disorder (mostly Major Depression) than mothers of children with School Phobia (Last et al., 1987a). The study also revealed that compared to School Phobic children, children diagnosed with SAD were more likely to meet another DSM III diagnosis and be more severely disturbed than School Phobic children. Wenar (1994) also suggests that vulnerability to developing SAD may be increased by an insecure attachment, by separation traumas that were uncontrolled and unpredictable, and by a temperamental vulnerability to anxiety in infancy. Whatever the interplay of predisposing factors, SAD usually develops in response to a specific life stressor such as the death of a parent, relative or pet; an illness of a parent or child; or moving to a new neighborhood, school or immigration. As we see in the case illustration to follow, 10 year old Henry developed SAD in response to his family moving across country coinciding with a surgery being scheduled for his mother.

Children with SAD tend to come from families that are described as "close and caring." Different family interaction patterns can occur (some SAD children are compliant, conscientious, and eager to please), but the most common interaction pattern researchers have identified is a "hostile-dependent" relationship between mother and child. Children with this disorder are often described as demanding, angry and in need of constant attention - dominating
an indulgent mother who gives in and reinforces the child's demandingness (Herbert, 1974). We will see this close intertwining of anger and dependence in the subsequent case study of Henry.

Gardner (1985) describes mothers of SAD children as "overprotective" - not allowing the child to individuate. Like Henry's mother, they often view the world as "dangerous" and can only feel secure themselves by staying close to the child. As a result, they are often vigilant about the child's whereabouts and constantly "check up" on him or her. Important treatment complications occur when therapists must differentiate these types of parental insecurities from the reality based threats of crime, neighborhood gangs and school violence, as it occurs in the case study to follow. Indeed, given the high levels of uncontrollable and unpredictable traumas for inner city children, distinguishing between a mother's realistic concern from overprotectiveness may be difficult. Further, the disruptive nature of these traumas make children's attachment issues and fears regarding separation reasonable. Thus, therapists working with children who live in dangerous neighborhoods have the additional task of addressing the impact of that environment on both the children and parents' behavior and affect. Mothers of SAD children also tend to shelter the child from facing interpersonal problems with peers and others because she perceives the child as "too weak" or "vulnerable". Unfortunately, this "benevolent" act further undermines the child's initiative and sense of efficacy, making him/her fearful to venture out. The result may be further dependence and demandingness, both
of which may validate the mother's perception of her child as vulnerable and needy of her protection, fueling further this unhealthy parent-child cycle of overprotection and dependence.

In addition, Gardner emphasizes that there is no meaningful marital coalition in this prototypic family scenario. Father also fails to provide a corrective parental influence on the child, as he accepts the mother's authority passively, is dependent on her as well, or is simply uninvolved in childrearing. In many families with SAD children, father and child are seen as being in competition with each other for the mother's interest and attention. Much familial conflict results from this competition and lack of marital coalition as mother and child remain enmeshed in their primary alliance with each other. These issues will be further elucidated in the case illustration to follow.

Socio-cultural factors contribute to and complicate the treatment of Separation Anxiety Disorder. These factors are varied and many, ranging from economic influences to the lack of education. Language, religious, and attitudinal differences about institutions and child-rearing practices can be factors as well. Henry, the client in this case, is a ten year old Hispanic boy, who lives in the inner city of a major metropolis on the West Coast of the United States. The client was born in the United States, his mother was born in Guatemala, and his father was born in Mexico. As we will see, these and other socio-cultural factors are significant in the development and maintenance of Henry's presenting problem. Before beginning the case study, we will examine
several specific cultural factors that may influence the development of SAD in Hispanic children.

The nature of the world as the child perceives it, is influenced by the nature of his/her relationship with the primary caretaker, and indirectly by the manner in which the primary caretaker views the nature of the world for herself. The caretaker's world view is colored not only by the relationship the primary caregiver had with her own caregivers, but by socio-cultural variables as well. Economic factors can influence the probability of real threats in the environment, therefore contributing to a view of the world as a potentially threatening place. This view may be communicated to the child. Further, when dealing with a population from a low socioeconomic level, the incidence of real crime and possible harm is often greater. By being forced to live in the inner city because of low wages and limited sources of transportation, these people frequently experience violence as a part of their everyday existence. In addition, gang activities, shootings, drug dealings, robberies, car jackings, molestations, and kidnapings are on the rise in the inner cities of the United States, making fear of becoming a crime victim increasingly a real concern which can realistically affect the behavior and attitudes of those living amidst such turmoil. These reality based fears about the possibility of harm make it more difficult for a parent to encourage age-appropriate individuation in a child. Similarly, a therapist's desire to encourage a parent to support their child's separation can be stifled by the therapist's own anxiety which is evoked by
witnessing and hearing of such violence. Thus, an important treatment complication occurs with this population because the therapist would like the client to behave more assertively and independently, but the therapist too may be realistically apprehensive about potential dangers in the community. As we will see in the case study to follow, the therapeutic task is to assess and address the degree of actual danger which may interact with and/or exacerbate the psychological dimensions noted earlier.

Families moving to the U.S. also have to deal with the stress of immigration itself. Many who come from Central America have lived in areas where Post Traumatic Stress Disorder is more prevalent, whether or not they themselves were exposed to war and its consequences (Cervantes, Salgado, & Padilla, 1989). These families have often been torn apart with hopes of being reunited at a later date. The multiple separations many of them experience can negatively affect the separation/individuation process for children who have a parent with this background, which may be exacerbated by their apprehension about the American lifestyle (Padilla et al., 1988). Cervantes et al. (1989) report that those families who have immigrated for political issues, and who have been exposed to war and dealt with leaving family members behind, can suffer from a significant degree of depression and anxiety. Central American countries, such as Guatemala or El Salvador, have a political history of civil war in which atrocities against the poor and powerless were committed by brutal governments. When a primary caretaker comes from this region, it is often
difficult to trust government organizations such as hospitals, school, or governmental agencies. It can take much education and many corrective experiences before this population may be able to trust and utilize government agencies beneficially. Leslie and Leitch (1989) speculate that in spite of the high level of services available to immigrants, low utilization may also exist out of the fear of being identified as undocumented. This fear of deportation is further increased by a recent California State Law (Proposition 187) which not only denies access to medical, educational, and social services to immigrants, but also dictates that the foregoing agencies need to notify the authorities when contact is made by undocumented individuals. Unless situations reach "crises levels," Central Americans will not seek out social and mental health services. Informal social support is often used rather than formal social services and, as a result, their interaction with the larger community is diminished and they may become insulated (Leslie, 1992).

Beyond the realistic potential for harm in the clients environment, language barriers can cause social isolation and the underutilization of mental health services (Acosta, 1984). In recent immigrant populations, failure to acquire the language of the dominant culture may lead to a sense of helplessness and powerlessness and may promote misunderstanding. Everything a person understands about the new culture must be interpreted or inferred and, in this process, accurate or undistorted communication may not occur. The dependence of parents on interpreters, such as their bilingual...
children is one common solution. In my clinical work, I have noticed that bilingual children find themselves in situations where their role as translators is useful to the family and helps them in their self-esteem in that they feel needed and appreciated. On the other hand, in cases where dysfunctional family relations exist, the bilingual child's role as interpreter can become overburdening for the child and contribute to a grandiose sense of importance, such as the child feeling responsible for his/her family receiving benefits while translating at a social service office.

Parents from lower socioeconomic groups often have less education and poorer reading and writing skills than their children, causing further reliance on their children (Acosta, 1984). In families where parent(s) possess high self-esteem and healthy interdependency between family members exists (Cervantes & Arroyo, 1994), the role of translator can provide children with an opportunity to develop positive social and language skills that increases their self-confidence. If, on the other hand, parent(s) lack self-esteem and are overly dependent on their children for emotional security, then the parent's dependence can make it difficult not only for the parent to let the child individuate, but also puts an unnatural burden on the child to care for the parent. This dependent relationship can further create a sense of shame and lack of confidence within the parent and a false sense of omnipotence within the child. The image of the caregiver as a steady and dependable support for the child is also upset by this role reversal, making it difficult for both parent
and child to let go of each other. Thus, an important and special feature of treatment with SAD populations where a bilingual child is the family's interpreter may include addressing parental deficits in language, reading, and writing skills in order to increase the parent's self-esteem and sense of independence, while freeing the child of this caretaking burden.

Other economic and cultural factors can make the separation-individuation process more difficult for this population. In the home countries of this population, families are typically large and extended. It is not unusual that there are many children with a wide range of ages, and that other family members such as grandparents, godparents, aunts, uncles, and cousins live together or in close proximity. Often, the family needs are given great importance over the needs of the individual (Alvirez & Bean, 1976; Grebler et al., 1970) with the family orientation often extending to other family members (Grebler et al., 1970). When this family system functions normally, it is unusual for a child to become overly dependent on one person because a child usually has numerous loving caregivers. This can, in addition, provide for emotional and financial support, including work exchange, refuge, problem-solving (Grebler et al., 1970) and assistance with the immigration process (Padilla, Cervantes, Maldonado & Garcia, 1988). Within a functional family system, a child has the opportunity to develop several primary relationships with godparents, aunts, uncles, and siblings, that can help them with the individuation and socialization process (Garcia-Coll & Meyer, 1993). If the
family experiences separation through death or immigration, however, familial support in child rearing is often lost and a problematic dependency among the remaining family members may result, eliminating the help the family can provide in dealing with anxiety and distress (Acosta, 1984). The lack of family support is clearly evident in the case of Mrs. H., whose resources in dealing with the anxiety and distress resulting from immigration and other stressors is limited.

The arrangement of living spaces is also sometimes changed by the immigration process. Many recently immigrated families with limited resources live in single room dwellings where parents and children sleep in the same room, rather than in separate bedrooms as is the custom in American families. The earlier separation from the caregiver in the United States (exemplified in having a separate bedroom) establishes the value for autonomy which comes earlier in life. Evaluating the sociocultural context of infant development (Garcia-Coll & Meyer, 1993) is very important given that children from different ethnic groups place a stronger emphasis on interdependence and cooperation (Kagan, 1977). Thus, the implications of having separate bedrooms may differ for different ethnic populations. In addition to having separate individual spaces, there are differences in the ages at which children are encouraged to become independent. In mainstream America, children may be encouraged to become more independent once they enter school, around age five, whereas in many Hispanic cultures, independence is not encouraged until later years. In
my clinical experience, however, immigrant children sharing living spaces are still able to develop autonomy, separateness, and independence.

It is possible that some of the traditions found in Hispanic cultures may also exacerbate the development of Separation Anxiety Disorder. In some cultures, having children is perceived by parents as being more valuable than it may be in segments of mainstream American society. Bearing and raising children can actually enhance the status of the Hispanic family. Also, the first born male child may carry special status due to family inheritance and leadership traditions. Thus, in many homes, Hispanic children might have less structure imposed by parents and are often perceived as the center of family life. These factors could make the parents of a child with Separation Anxiety Disorder feel less comfortable with imposing the firm limits and consistent consequences that are necessary to alleviate the symptoms of Separation Anxiety Disorder. In trying to follow the standard treatment guidelines (for example, sending the child back to school even though he/she does not want to), the parent may feel as if they are betraying cultural values. Thus, the conflict arising from what appears to be an appropriate treatment goal clashing against a cultural value would need to be assessed and addressed.

In diagnosing SAD, it is critical that the therapist distinguish between behavior that is normative and adaptive from behaviors that are maladaptive and inhibit the growth and development of the individual. However, as
Cervantes and Arroyo (1994) indicate, before diagnosing separation anxiety, it is important to take into account family values of interdependence, neighborhood norms, and forced and multiple separations. Some cultural groups place a high value on strong interdependence among family members as opposed to values of independence. Mexican American youth represent a group in which interdependency may often be encouraged. Kagan's (1977) literature review, for example, documented that Mexican American children are more concerned than other children with cooperative motives rather than competitive motives. This form of socialization has great value and can help a group overcome hardships and maximize their resources. This is especially relevant for Hispanic families who may be faced with the stress of unemployment, financial difficulties, language barriers, and adapting to a lifestyle of the United States. Further support for the beneficial effects of social support is provided by Padilla, Cervantes, Maldonado and Garcia (1988), who found that social support networks for Mexican and Central American immigrants have been very helpful coping resources in dealing with the above stressors. Family and friends were identified as the single most important factor in assisting the immigrants transition into the United States. In the present case study of Henry, however, the lack of extended familial and community support fostered the developmentally inappropriate dependence between the mother and the child, which in turn created further familial problems by precluding an emotional relationship with the father.
Finally, treatment of the entire family system is also made difficult by the fact that employment opportunities are rare in the inner city and, if there is hope for continuing employment, long hours, few days off, and an inflexible work schedule are to be expected. Because of these factors, conjoint sessions with working parents, which would be helpful in the development of a therapeutic alliance and realignment of family roles, are difficult to arrange because they may threaten greatly needed family income and jeopardize job security. The impact of such factors will be addressed in the following case example.

Case Illustration I

Henry was brought to an inner city family health clinic by his mother. For the previous two months he had been reporting stomach pain, headaches, difficulties sleeping alone at night, reluctance to attend school, and resistance to leaving home without his mother. Prior to the clinic visit, Henry had received a physical examination from his pediatrician who was unable to find an organic basis for his somatic complaints. His mother requested a second opinion from our health clinic. The family physician at our clinic also found no physical problems and requested a psychological evaluation by me, the clinic's psychologist and a bi-lingual Hispanic man.

Henry's mother indicated that Henry had a history of difficulties with separation beginning in preschool. Throughout preschool, his mother reported that Henry would cling to her, be tearful if she left his sight, and complain of stomach aches. After his first three months of kindergarten, the family moved
to the east coast of the United States when Henry's father received a better job opportunity. Henry's symptoms of anxiety increased at his new school, where his attendance was sporadic and academic performance correspondingly poor. For these reasons, his teacher recommended he repeat kindergarten. Henry was then referred to a psychologist and he seemed to respond well, with some decrease in symptoms and improved academic performance. Unfortunately, the treatment terminated prematurely when the family was unexpectedly forced to move back to the inner city on the West Coast after Henry's father experienced work-related problems at his East Coast job.

Upon arrival on the West Coast, Henry was placed in the third grade instead of the second because of his age. Three months after moving, he exhibited symptoms of Separation Anxiety Disorder again. In addition to separation fears, the family's moves and Henry's excessive school absences had disrupted Henry's ability to develop peer relationships. Similarly, his mother's opportunities for establishing social support through community activities were also disrupted by these moves.

Henry's mother (Mrs. H.) also reported that she had been suffering from severe stomach pains which were the result of gall stones. Her physician had recommended hospitalization to remove the stones, but she postponed scheduling the surgery after Henry began showing symptoms of SAD once again. At a time when she was worried about her health, Henry provided companionship and comfort while her husband was consumed by work
responsibilities, and she welcomed Henry's attention and dependency.

Henry was in the third grade when he first came to the clinic. He was a tall thin boy, with pale skin tone, in contrast to his mother's olive complexion. At his first meeting with the therapist, he was neatly dressed in a T-shirt, jeans, and a popular style of tennis shoes which appeared to be recently purchased. During the initial interview he sat close to his mother, did not make eye contact with me, and spoke in a low monotone voice. His affect was restricted, he answered with head nods or nonverbal gestures, and he often looked toward his mother who would respond for him. While Henry spoke both English and Spanish, his mother spoke only Spanish. On occasion, Henry would speak English with me. When this occurred, Henry's mother would sit with a lost look on her face, clearly not comprehending what Henry was saying. Because Henry was born in the United States, he qualified for Medi-Cal coverage which paid for physical and mental health visits.

Henry lived in a one bedroom apartment with his natural mother and father. The apartment was located in the heart of the inner city, in a neighborhood that was primarily Latino, with the majority of the population being recently immigrated Mexican and Central American refugees. Gangs and drug dealers were a major problem in the neighborhood, and community resources were limited. Henry attended a local public school not far from his home. The class was overcrowded and resources for "after school" programs and recreational sports were limited.
Because of the mutually dependent mother-child relationship in most cases of SAD, it is important to include information about the mother of the child. Mrs. H. was 42 years old and slightly overweight. She was very polite and respectful toward me. Her attire suggested that she was from a lower socioeconomic group. She wore a simple T-shirt, shoes that were very worn-out and faded shorts. Her dress, in contrast to Henry's, was noticeably more tattered and frayed. She was unadorned, with no makeup, and her graying hair was pulled straight back. Nonetheless, she carried herself with pride, and her greatest source of pride appeared to be her son.

Henry's mother, Mrs. H, was born in Guatemala, the second of five children. For unknown reasons, she was given to a paternal aunt who admired her during a family visit at the age of one year and nine months. After several months of living with her aunt, her grandparents believed that she was not receiving adequate care, so they took her to live in their home. Consequently, Mrs. H felt very close to her grandparents and considered that they were more her parents than her biological parents. Mrs. H was still confused and resentful over the willingness of her mother and father to give her up. As an adult she confronted her parents about their reasoning for giving her away, but this confrontation was not productive and did not provide her with any useful information to help her resolve her feelings of rejection and abandonment.

Mrs. H. lived in Guatemala until the age of 33, and she completed a sixth grade education in her home country. At the age of 17 she became sexually
active without the use of contraception, but never became seriously involved in a relationship or pregnant until she approached her 30's. At that time, she became involved with a man who was unwilling to commit to her. She was afraid of "being alone" for the rest of her life, and began to try to conceive a child by calculating the most likely times of conception and planning her relations with her partner accordingly. Considering Mrs. H's history of profoundly insecure relationships, it is possible that she viewed the possibility of a relationship with a child as something permanent, a bond that she might finally control. Mrs. H suspected that she might be pregnant, but as the relationship grew apart and she realized that her partner would never be willing to make a long-term commitment, she decided to move to the United States with members of her extended family.

Upon arriving in the United States, Mrs. H. began working in a factory to support herself. She reported that after living in the United States for five months, she discovered that she was indeed pregnant. She stressed that she immediately sought prenatal care from a county clinic and was pleased about being pregnant. Mrs. H wrote the father of the child but received no response. She decided to continue with the pregnancy, believing that she could do a satisfactory job of raising a child on her own as a single parent. Tragically, the female infant was delivered stillborn, due to a malformation in the brain. Unfortunately, Mrs. H was not given an opportunity to see the infant post delivery. Consequently, Mrs. H. suspected foul play or a major error by the
hospital, in particular suspecting that her and the infant's identification bracelets may not have matched correctly. Believing that the infant had not really died but was somehow switched or taken may have been an attempt both to defend against her own deep feelings of abandonment and inexplicable loss, as well as her own feelings of shame and humiliation over delivering a stillborn child.

Several months after the stillbirth of Mrs. H's daughter, Mrs. H. met Mr. H, Henry's father. He was 29 years old and had recently immigrated from Mexico to the United States. They married about a year and a half later, and Henry was born about six months later when Mrs. H was 36 years old. Mrs. H described Henry's father as a "hardworking" and "good man", and she reported that she felt "safe" with him. Mr. H was employed in the fast food restaurant business. He and his wife had met on the West Coast of the United States, then they had moved to the East Coast where they had lived for a little over two years when he accepted a job in fast food management. Mr. H decided to leave his position when he found out that his boss was involved with dangerous individuals, and he became concerned for the safety of his family and himself. This experience also served to reinforce the family's perception of the world as a dangerous place. At intake, Mr. H was working long hard hours as a cook in a fast food business without benefits. Henry's father was not able to attend therapy sessions often because any hours missed from the low-paying work would result in financial hardship for the family.

Mrs. H's only complaint about her husband was the way he treated
Henry--particularly how strict he was and the manner in which he would intimidate Henry into complying with his requests. Mrs. H said that Henry and his father had a competitive relationship in which they were rivals for her attention. Mrs. H reported that Henry often slept in his parents' bedroom, even though they had arranged a designated place for him to sleep on the sofa in their living room. His mother admitted that she felt sad for him because "he looked so lonely sleeping all by himself", so she would routinely have him sleep with her. Mr. H would feel overcrowded and slighted by his wife's decision to put Henry between them, so he would sleep on a second mattress in their bedroom. Because of Mrs. H's own deprivation and insecure attachment in childhood, the concept of being alone seemed to have taken on special significance for her. She was unable to sustain a primary marital coalition with her husband and she was unable to set or follow through with firm limits for Henry. Henry often complained that his mother gave his father more attention than he received and that he was entitled to an equal share. Mr. H responded by ineffectually explaining to Henry that someday he would grow up and find a wife as good as his mother. By this, Mr. H was hoping to reduce Henry's insistence on demanding a disproportionate amount of his mother's attention. In response, Henry would become upset and continue to demand all of his mother's attention. This adoration and competition for Mrs. H's attention seemed to be highly reinforcing for her. Her relationship with her husband and son did provide a much needed contrast to her childhood experiences of
rejection and abandonment, and in her relationship with the father of the stillborn child. As a result, she had difficulty in setting limits that were necessary to ease the conflict. If she stopped this competition for her attention, she would be giving up the much needed, constant reassurance that she had never received in her life.

In the first session Henry was quiet and spoke very little. I wanted to establish an alliance with both Henry and his mother so I saw the both of them together for about 15 minutes:

Th.: Hello Henry, it's nice meeting you.
He.: [Henry nods but avoids direct eye contact].
Th.: Maybe you can tell me what has been bothering you.
He.: My stomach has been hurting me a lot. [long pause...his mother looking at me and wanting to speak but restraining herself given that I'm giving Henry direct eye contact].
Th.: Do you know what has been making you feel that way? (wanting to assess insight or ability to reflect upon himself).
He.: I don't know, it just hurts me [he responds abruptly].
Th.: Gee...that must feel uncomfortable. How long has this been going on?
He.: I don't know [his mother cannot restrain herself any longer and then interjects].
Mo.: Excuse me doctor, but this has been occurring for a few months now
Th.: [At this point, I decided not to be too directive and ask questions more open endedly to observe mother-son dynamics]. Oh, so what happened a few months ago?

Mo.: [She continues speaking...as mother speaks, Henry looks directly at her and makes occasional nods]. There are some boys in his school that have been bothering him, hitting him. One of them is bigger and despite telling his teacher nothing seems to be done.

Th.: I wonder what rough things they are doing [I ask open endedly again to see if Henry can jump into the conversation in any way and give his experience].

Mo.: [looking at Henry] Tell the Doctor what they do to you... [She makes it easy for him, he doesn't have to struggle to think or talk in their relationship. She directs him when to speak, and if he pauses or has trouble finding words for his experience, she steps in to express her opinions].

He.: When we were on the playground the other day, one of them came up to me and kicked me and hit me on the back [speaking in a frustrated and annoyed tone]. And the teacher didn't do anything when I told her....(pause)...[Mother interjects].

Mo.: These boys, doctor, I'm worried because these are bad children who seem to be dangerous.
In the very first few minutes of my session I was faced with trying to distinguish between parental overprotection and realistic concerns given the violent nature of Henry's community. On the one hand, the information (and the manner in which it is presented) may be a reflection of an overprotective mother who has not allowed Henry to become comfortable with his aggression and to protect and defend himself as other boys his age. On the other hand, as Cervantes and Arroyo (1994) indicate, neighborhood norms can often involve violence and gang activity causing anxiety in these situations. I decided to be safe since I was unfamiliar with Henry's specific school [I was aware that his neighborhood had a reputation of gang violence] and validate his concern so I could establish an alliance with him and his mother. I felt that if I was playing into any manipulation of either mother or son, there would be plenty of opportunities in our future sessions to address it rather than risk misinterpreting a reality issue.

Th.: Gee, sounds like the teacher's not listening makes you angry. Mrs. H., how does that make you feel towards the school?

Mo.: Well Doctor, I'm very worried about something happening to him, and the fact that the teachers aren't putting a stop to these kinds of things does not seem right. I'm not an educated woman [I have many Hispanic clients who are very humble when they present an opinion against a professional's] but I think
something should be done to these students [Henry nods his head in agreement]. I worry how safe he will be at school.

As mentioned earlier, separation anxiety involves aspects of the mother-child relationship. I decided to meet with Mother alone to establish an alliance with her and not threaten the dependent relationship with Henry. Meeting with mother alone would also help further clarify the extent of Henry's separation problem. Thus, Henry was directed to a waiting room next to the therapy office with the door closed.

Mo.: Doctor, this problem of his stomach aches and not wanting to go to school is something that began since pre-school [Her tone sounded as if she could speak more freely]. He had been doing better after working with a psychologist when we lived on the East Coast. Teachers from Head Start to Kindergarten were very good at understanding him and helping me with him. I was very grateful for that......[Mother spoke non-stop, to the point that it was difficult for me to interject questions. I sensed some desperation and experienced a neediness about her that made me want to pull away from her. At the same time, however, I was compelled to help her because I felt compassion for her predicament. I decided that gathering background information would be the best use of the remaining time].

After several minutes into the interview, there was a knock at my door.
Smiling, mother said, "I'll bet that's Henry." Opening the door, it was Henry.

He.: How much longer are you going to take? [He looked disapproving rather than anxious. He also seemed to want his mother to invite him back in].

Th.: I know it's difficult to wait outside.

He: Cause your taking a long time....[He sounded whiny. He must have been quite angry at me for intruding upon his special relationship.]

Th.: You sound really upset at us for making you wait outside...[pause]...I can understand you feeling this way...I need your help [trying to make him feel a part of our relationship], I want to talk alone more with your mother about some very important information. After she's done, I want to talk with you again and I will let you know what things she and I review [When separated from their mother, these children often develop elaborate fantasies about what is being talked about, and answering their questions can help reduce their anxiety]. He nodded his head in agreement.

Mo.: [proudly] I knew he was going to have a hard time with waiting and I expected him to knock at the door.

Th.: You did?

Mo: He likes being with me a lot and wants a lot of my attention.

Th: How does that make you feel?

Mo: I like it that he needs me...but aren't all children like that with mothers who love them?
During the time remaining, Mother provided some background history and complained about Henry's opposition over homework assignments. I saw her complaining as a good sign that she could separate somewhat from him. On the other hand, she wasn't able to do this with him in the room. In fact, she asked me to instruct Henry to complete his homework assignments and to comply with her requests. She also asked me not to share with Henry the source of this information concerning his non-compliance.

I was immediately concerned about the possible development of "alliances" and felt strongly the need to set boundaries and clarify my role. It also seemed important that I find a way to model being engaged yet maintaining my separateness. My concern, however, was that she not experience me as critical, judgmental, or rejecting.

Th: What I would like to do is be able to find a way to instruct Henry so he will pay more attention to what you say. I also think it is best that we not keep secrets from Henry or else he won't trust us and the three of us will have difficulty working together. How do you feel about the three of us working together to get Henry to complete his work and for you, as his mother, to have a reasonable authority role with him? After I talk to Henry there may be some things he would like different at home too and we will talk about them later and see if they are reasonable things to work on.

Mo: Ok, Doctor. Whatever you think is best [her comment felt genuine].
I brought Henry back into the room and told him (with his mother present) that she had told me about his stomach aches and the difficulty he sometimes has getting his homework and other things done and that we had agreed to work together to improve the situation. I then stated that I wanted to spend time alone with Henry to hear things from his point of view. Mrs. H seemed surprised at this. I thought it important at this point to address Henry directly. I stated to him that I wanted to spend time alone with him and that we could play with toys and talk together for a while [In this process I was attempting to delineate one clear boundary. That is, that Henry and I would also have a relationship that was separate from the one I had with his mother]. I then turned to Mrs. H and thanked her for the information she had given and said that Henry and I would be done in 20 minutes, at which time the three of us would briefly review the session and make plans for future meetings.

An issue that often arises when working with children is the extent to which individual time gets shared with parents. My policy when working with children 10 and older is to ask what occurs during the individual segment be confidential (between child and therapist) with the proviso (stated clearly in the child's presence) that we would tell the parent if the child were engaging in dangerous behavior (e.g., using IV drugs) or were suicidal. Otherwise, the specifics of the session would not be divulged unless the child and I agreed to this in advance. Mrs. H seemed distressed by this but agreed after I explained
the importance of giving Henry the opportunity to express all he thought and felt without fear that it would be told to his mother and potentially displease her. Mrs H then reluctantly left the room. Although I utilize these guidelines with most clients, they were particularly relevant given the boundary issues between Henry and his mother. *Clarifying these boundary issues was essential, otherwise the same problematic dynamics that occurred in the family would be reenacted in treatment.*

After Mrs. H left, I was aware that Henry didn't seem interested or show curiosity about me and the items (toys, pictures, colors) in my office as other children who often either get out of their seats to touch the toys or at the very least look at from far away. He still seemed more focused on his mother. I warmly invited him to explore the room and explained to him that the purpose of therapy was to talk openly and see if we could together find a way to help him feel safer and enjoy school and his family. By speaking directly to Henry, I hoped to communicate that the therapy environment was one of trust safety, respect, and openness and that he, as an individual, was a central part of this process. Henry spent most of our time sitting in the same chair but did convey his interest in trains (his family had traveled this way from the East Coast). He also said that he might like to be a pilot when he grows up. His interest in various modes of transportation was fascinating given his presenting problem: fear of separation.

At the end of this intake, I asked Henry and his mother if they would like
to be in treatment with me and stated that there were other resources I could provide if they did not feel comfortable with me. The mother stated that she wanted to pursue treatment with me because she felt a great sense of respect, courtesy, and understanding from me. I thanked her and told her I would do my best [with Hispanic patients I often find that at the end of sessions there is often a humbling back and forth interchange between myself and them].

A case conceptualization of Henry developed, I realized that Henry's complaints of stomach pains and separation difficulties could be understood by examining his parent's background, his relationship with his parental figures, his school, and his culture. Henry's mother had difficulty tolerating separation from Henry, due to her own early separation experiences. In her early background, her first attachment was tenuous and prematurely disrupted when, without warning, she was removed from the home where she lived with her parents and older sibling. The reason for her removal was never communicated to Mrs. H, and contributed to her sense of the world as an insecure, uncontrollable, and unpredictable place. She was left with feelings of doubt about her own desirability and self worth. The result of such abandonment and rejection experiences seemed to have generated insecurities that served to influence her inability to establish a committed relationship throughout her teens and early adulthood. My experience with her in the initial session, which suggested that she was very needy, wanted frequent affirmation, yet also wanted to control the pace and direction of our time together, gave me insight into how others might
have experienced her--demanding and controlling.

Mrs. H's desire to conceive a child out of wedlock may be perceived as an attempt to feel whole and desirable. Perhaps in a relationship with a child, she would finally have someone to love and someone who would love her completely in return. This child would depend on her and never leave her as others had before. After many years of not using birth control, she finally conceived this child and began to foster hopes that this pregnancy might help her to overcome her sense of herself as defective and undesirable. Through this pregnancy, she might have finally been able to experience herself as worthy, capable of creativity, and capable of preventing "unexpected disruptions." Moving to the United States also may have offered her the hope of building a new, more secure and fulfilling life. However, all of her hopes for a new start, a new sense of self, and her new attachment to a new country were shattered by the stillbirth of her daughter and the difficult social and economic conditions she faced in her new country.

The marriage to Henry's father and Henry's conception again inspired a sense of hope and trust in the future. However, her pattern of self doubt continued as evidenced in her perplexity concerning why Henry's father might be attracted to her, especially considering the fact that she was five years older. However, this age difference had a "positive" side in that it was more probable that her husband would become dependent upon her, satisfying her desire for someone who would need her, cherish her, and never leave her. Further,
although this new marriage and pregnancy inspired optimism, it could also have re-evoked the trauma of losing the first child. Although fears of fetal demise are common for many women, they are all too real for a woman who has had a previous experience with fetal death, malformation, or trauma. Memories of the death of her own childhood through separation, the real death of her first daughter, and the death of the relationship with the first baby's father may have been re-evoked. Fears that she must somehow be defective given her repeated rejections and losses were also understandably evoked. She was, to some extent, delightfully betrayed when her negative expectations were not realized, and Henry was born alive and healthy. Mrs. H could now hope for a brighter, more emotionally secure future with a husband and son who would love her and not leave her.

After Henry's birth, Mrs. H became suspicious about not seeing her daughter's body after the delivery. She noted that when Henry was born, his identification bracelet number and her own were identical, while she recalled that the numbers on her daughter's bracelet and hers were different. She requested medical records from the hospital for her daughter's birth, but was unsuccessful in acquiring them. Mrs. H wondered if there could have been malice or error involved in this matter. She considered that her daughter could have been switched with the deceased child by a staff member, or that it might have been a case of mistaken identity. For many years she has felt that her daughter was still alive and she wrote to various officials requesting their help.
She reported that she had been constantly told that there was nothing that they could do. Though it is possible that such a mix up could occur, it was more likely that these suspicions served to defend Mrs. H from dealing with her own feelings of loss and grief for the child, feelings which were intolerably exacerbated by her own extensive history of loss. This unresolved issue had tremendous impact on Mrs. H's relationship with Henry. On the one hand, she was distressed and preoccupied with her own concerns, but at the same time, intrusive and demanding of his full attention and devotion. Burdened with the knowledge of his mother's great pain regarding the loss of her daughter, Henry found it difficult to separate from her and become an autonomous being with interests and activities that did not include his mother.

Further, Mrs. H's preoccupation hindered her ability to relate to Henry's needs and allow his separation. Her suspicions regarding her first child's birth supported her concept of the world as a hostile environment. Given this, how could she ever feel confident in allowing her child to explore the world on his own? Thus, in addition to not wanting to "leave" his mom because of the pain it clearly caused her, Henry was also beginning to internalize his mother's view of the world as a hostile, unsafe place. He began to accept her verbal and non-verbal messages that he could not manage his way in the world without her, and that emotionally she could not manage without him.

Because Henry was born into a relationship where he was always competing for his mother's attention, he became anxiously attached to her. He
never knew when she would be emotionally available to him, or when he would be shut out by the sadness and losses of her past. Due to the obsessive preoccupations about her stillborn daughter, and the unremitting grief surrounding the unrequited love for the father of the first infant, she was often unable to be emotionally present for Henry. Similarly, Henry's father also experienced Mrs. H's preoccupation and emotional absence. In reality, neither Henry nor his father could compete successfully with Mrs. H's memories, sorrows, or preoccupation. They could, however, compete with each other for the time she was emotionally available, and this is what they did vying for control of the small part of her that was intermittently available to them.

Unfortunately for Henry, he did not have a father who was physically and emotionally present to provide a correcting buffer to counter his mother's inconsistent and insensitive parenting. Henry's father worked a great deal and, when he was home, he was often fatigued. Mr. H expected Henry to be unquestioningly compliant. He also harbored some anger at Henry's "intrusion" on the marital dyad, particularly since Henry usually slept with his mother while he slept in another bed. Clearly, family roles and intergenerational boundaries were not appropriately defined, and Henry and his father often behaved like siblings fighting for the mother's attention. Mother had difficulty setting firm boundaries with Henry but also undermined father when he did. Further, the marital coalition lacked strength, with mother taking sides with Henry in criticizing the father's "harsh" manner. While the mother believed that the father
was too dominating, the father felt that the mother was too permissive. Thus, the primary alliance in this family was between mother and Henry, and lacked a viable parental subsystem. This precarious balance suggested the importance of working with the whole family to define more appropriate roles and re-align the structure of familial relationships.

As I examined Henry's relationship with school I realized that his perception of school was a negative one. He wanted to avoid school and stay home partly because of his anxious attachment to his mother and partly because he did not want to respond to the structure and demands imposed by the school setting. He attempted to rationalize this avoidance by externalizing blame onto the school, the teachers, the students, and the system of rules. That Henry had difficulty with initiative, peer relations and completion of his school tasks is not surprising. Historically, Henry's attempts at autonomy and initiative were sabotaged by his mother's messages, i.e., that this would represent a loss to her and bring her more pain, and that he was weak and needed her because the world was a dangerous place. Any anger Henry might have felt regarding this sabotage could not be expressed directly or assertively to his mother. Further, not taking responsibility for school behavior was safe since his mother collaborated with him and joined him in blaming others for family problems.

Cultural influences that affected Henry, included the fact that he was a child of parents from two different countries, living in yet a third country.
Because of this, he was faced with significant cultural and identity conflicts. His mother's birthplace, language, and physical features were Central American and his father's Mexican American. These differences, and the animosity which existed within his community between Mexican and Central American families caused him tension and anxiety. Further, within his isolated inner city home, Henry lacked healthy role models for relating to others and the world. In his school, he looked physically different from many of his classmates and teachers, adding further to his sense of isolation and disconnectedness. Henry's insecure and anxious attachment in his home was further exacerbated by cultural factors: his family's unstable economic status, the dangerous, volatile neighborhood in which he lived, and the fact that the larger society often devalued people from his ethnic background simply on the basis of their physical characteristics. Thus Henry was faced with integrating the cultures of his mother and father as well as the culture of the community within which he lived (Garcia-Coll & Meyer, 1993).

Mrs. H's history of disrupted attachments made it difficult for her to provide Henry with a secure base from which to launch and become an autonomous, curious, active, joyful child. She sought from Henry the utter devotion she lacked as a child. Any attempts by him to have interests that excluded her were experienced as rejections, further wounding her fragile sense of self. Although she wanted Henry's full attention and devotion, she was unable to give him adequate attention or responsiveness. She was often
preoccupied with thoughts of her dead daughter and with questions regarding her parents' reasons for giving her away as a child to relatives who didn't care for her (as evidenced by her grandparents having to remove her from that home). These factors made Henry's attachments to his mother tenuous at best--he would wound her if he separated from her but she never was fully his either when he approached her.

Beyond the issue of disrupted attachments was the issue of real and imagined danger in the environment. The unstable nature of their living situation, including lack of economic security, lack of social support and ongoing violence in their neighborhood, contributed to their sense of the world as a dangerous place. That Henry and his mother viewed the world and people as unkind, uncaring, and frequently actively malevolent is thus not surprising. Indeed, there were very few experiences in their lives that fostered a sense of trust and expectations of benevolence. Their experience and perception of the world as dangerous and people as likely to be malevolent contributed further to Henry's fear of venturing out and exploring his world. Staying close to his home and his family was the safest alternative. This alternative was not very satisfying to Henry but he lacked the language, emotional support, and psychological sophistication to articulate his feelings and needs. At some level Henry was angry at his mother for her neediness and demands for his full attention and devotion because it robbed him of his individuality. This anger was further fueled by her incomplete attention and devotion to him. Henry was
thus in a no-win situation—his only "safe base" was inconsistently available to him but he was not allowed to seek security elsewhere because other rewarding relationships would wound her and threaten what he did have with her. Henry's "resolution" was thus expressed in the form of somatic symptoms and fear of separation from his mother.

In the process of designing treatment plans and intervention strategies, I realized that medications play a minor role in the treatment of SAD. There has been some empirical support for the use of the tricyclic antidepressant imipramine (Gadow, 1991) but efficacy studies have been confounded by problems of comorbidity. It is painful indeed to see preadolescent children become sick to their stomachs or perspire over the impending threat of leaving for school in the morning, and it is equally sad to see parents tyrannized by dependent but demanding children. Fortunately, SAD is readily responsive to treatment.

For Henry and most children with SAD, the first therapeutic guideline is to have the child return to school as soon as possible without precipitating the dropout problem that results when the child is forced to return to school immediately without attention to his/her family situation (graduated steps for achieving this will be detailed for Henry and his mother). Family dynamics around the separation are immediately highlighted by this press for more independent functioning, as therapists usually find that the parent gives in and accepts the child's excuses for avoiding school or other separations. Therapists
treating SAD must anticipate this parental "sabotage" throughout the course of treatment. *Patiently and supportively,* therapists must repeat to the parent that when they give in to the child, they are contributing to the pathology. To enable the parent to stop indulging the child and begin setting firmer limits instead, the therapist must try to become the interim "secure base" for the parent. That is, by providing an empathic "holding environment" for the parent, the therapist can help the parent contain and manage more appropriately her own separation anxieties aroused by the child's departure. Within the relational context of the parent feeling understood and emotionally "held" by the therapist's attuned responsiveness, the therapist can: 1) help the parent adopt a more firm and authoritative stance with the child so that the parent can stop the role reversal underway and become the adult-in-charge; 2) help the parent better manage her own emotions internally, rather than through her child, by becoming better able to identify, experience and talk about her own unmet dependency needs and separation anxieties with the therapist; and 3) disrupt the problematic cross-general alliance between parent and child by finding new ways to involve the other parent (or other family members) in the child's life (e.g., father-child outings) and work to improve communication in the marriage so that the spouse (or significant others) can begin to hear and respond to the parent's emotional needs rather than the child.

Additional treatment guidelines involve the school. Therapists working with SAD need to establish cooperative working relationships with school
personnel. For example, it may be useful to place the child in a special classroom with a low class size. Much symptomatic improvement can result from increased interaction with the teacher and with other students. It is especially useful when the teacher can encourage a special buddy or otherwise facilitate a close friendship for the child. Therapists can also use the school setting to gradually wean children away from the parent by having the parent accompany the child to the classroom for short amounts of time at the beginning of school and gradually but systematically decrease the parental presence. If the child cannot attend school at all, s/he must spend time at home away from positive reinforcements of the home environment such as TV, toys and computer games to eliminate the secondary gains from being symptomatic. The cardinal issue, however, is that the SAD child will only begin to leave the parent more successfully when coaching from the therapist allows the parent to say to the child in a firm and unambiguous voice (i.e., without weeping or looking forlorn): "I will be fine while you are gone, and I want you to go to school now".

Short term treatment goals included: 1) providing a "holding" environment for mother so she could unambiguously encourage Henry's return to school; 2) helping mother gain insight into how she may inadvertently be contributing to Henry's separation fears; and 3) assessing and differentiating real from imagined danger in the school and facilitating Henry's return to school.

Intermediate treatment goals included: 1) providing Henry with a safe
therapeutic environment where he could play out/express himself, including his insecure and anxious attachment to mom and his fear of the world as malevolent; 2) helping Henry identify his needs, interests, and abilities and support all attempts at autonomy and initiative; and 3) strengthening the marital dyad and encouraging mother to seek nurturance and support from her spouse rather than from Henry.

Long term goals included: 1) helping the family identify interests and support systems in the community; 2) increase positive contact between Henry and his father; and 3) support appropriate family roles (parental, child, spouse).

The application of short term goals took form as I focused on Mrs. H's history of frequently disrupted attachments. This focus made it clear that she needed therapy in order for her to allow Henry to individuate. Since our center lacked another Spanish speaking therapist, I decided to divide each session into time alone with Henry, time alone with his mother, and time with both together. I planned to eventually include dad so that we could have the whole family working together.

In my sessions with Mrs. H, I tried to convey to her that I would do my best to be consistently available to her. I also stated my hope that as we explored her history, we would be able to understand better how her previous experiences contributed to her own and her family's current functioning. I hoped that the security provided by our relationship and insight on her part into
the genesis of her own (and Henry's) anxious attachments would make it possible for her to unambiguously encourage autonomy and initiative in Henry.

The initial "mother only" segments of the sessions were thus spent building the relationship which included listening, being empathic, and validating the disruptive nature of her losses. Mrs. H was able to share with me how fearful she often was when Henry was away from her--fearful that something might happen to him. We were able to work with this issue and connect it, for example, to the loss of her daughter and the reality of her unstable neighborhood where children were sometimes killed. We then brainstormed ways to increase her sense of security regarding the realistic dangers in the neighborhood and also differentiated Henry and his life-situation from that involving her deceased daughter. I encouraged Mrs. H to pay close attention to how she expressed (verbally, emotionally, behaviorally) these fears to Henry. I highlighted the long-term benefits of independent functioning for Henry and encouraged her to share her fears with me instead of acting them out with Henry.

In the "child only" segments, I encouraged Henry to find toys and play. I hoped that in this process Henry would begin to identity his own interests. I also hoped that this arena would provide Henry with a safe place to play and master his fears. Mindful of not re-enacting his mother's control and intrusiveness, I was careful not to be over-involved or intrusive so I kept my comments to a minimum. Henry often seemed conflicted about the extent to
which he wanted to include me in his play. He would sometimes deliberately turn his back to me or exclude me in some other overt way. However, he almost always came back to me and handed me the toys at the end of our session. Typically, my response was to say warmly "I'm glad you came in today, let's put these away together". Again, thinking about how our process could re-enact his conflicts, I wanted to communicate full acceptance of how he chose to structure his time (i.e., to make unambiguously clear that I was not angry or wounded by the exclusion). Putting the toys away together was important as well because I wanted Henry to realize that he also had responsibility for completion of tasks--including this one.

In the initial "family segments", we focused on getting Henry back to school. We discussed Henry's fears about the school setting itself and his complaints that several boys were bothering him. It turned out that they were not gang members and that there had been no reports of violence on the campus thus far this year. Henry was able to acknowledge that he could ignore them and spend his recess away from where they typically were. It seemed, from his description, that they enjoyed teasing him because he was easily upset but that they would likely be discouraged if he firmly said, "I don't like you teasing me" without crying, which we role-played and rehearsed. I accompanied Henry's mother to a school conference where it was decided that Henry would be placed in a smaller class. I was able to model for Mrs. H how to communicate with the authorities and get appropriate assistance. I also
asked the school about what programs were available to Henry (tutoring, free lunch, and so forth) and encouraged Mrs. H to use these as she saw appropriate. One program, which was recommended as soon as possible, was the Student Study Team (sometimes called the Child Study Team). The Student Study Team is a team composed of the parent and school personnel the referring classroom teacher, another classroom teacher who is an ongoing member of the team, the bilingual resource teacher, the resource specialist, the Chapter I learning/reading specialist, the school nurse, and the principal). The team meets on a regular basis, either weekly or bimonthly, to discuss a student who is not experiencing school success. Tests, student work samples, and anecdotal information are analyzed and discussed. Suggestions are made in the development of an individual learning program for the child. The mutually agreed upon suggestions of the team are recorded, including a schedule of the follow-up meetings, to monitor progress toward the goals for helping the student become more successful in school. Each member of the team signs the Student Learning Program and they receive a copy of the form, so that each can complete his part of the agreement.

Some examples of interventions that might be proposed by The Student Study Team include having the classroom teacher develop, monitor, and reward Henry for improved school attendance, using a Student Behavior Contract signed by the student, the teacher, the parent, and the principal. The resource specialist would arrange for the student to take a battery of tests to determine
grade level proficiency of basic skills, appropriateness of current grade placement in relationship to Henry's skill mastery, age, and social interaction with his peers. They would also need to determine if Henry could benefit from special services for remediation of basic skills, which might include tutorial services, reading or math lab services, or special education. The school principal might enlist the volunteer services of a high school or college student, teacher's aide, or parent volunteer, to tutor Henry after school several days a week to remediate math skills, reading and language acquisition, and/or writing skills. The Chapter I reading specialist (or bilingual resource teacher) could provide Mrs. H with a copy of the school's multicultural activities listed in the School Improvement Plan. They should invite Mrs. H to attend these activities to increase her understanding of cultural diversity. The Student Study Team should discuss the most appropriate classroom assignment for the student, matching Henry with the teacher who would probably be the most compatible both academically and emotionally.

In the classroom, the teacher could use numerous classroom instructional strategies designed specifically to increase success opportunities for the student on a daily basis. Some of these strategies include modifying time allowed to complete an assignment to meet the student's needs and abilities. The teacher could do a "time-on-task" assessment of the student's classroom behavior to identify ways to help the student increase task completion. Cooperative learning experiences should be provided as much as
possible to improve peer relations while increasing task completion. The teacher could modify the number of problems required for student practice to increase the student's attention span. By using small group instruction the teacher can reinforce learning and increase interest in the subject and skills. By providing more "hands-on activities," the student can experience more fun in learning. In using a multifaceted approach, the teacher would be more likely to meet the student's preferred learning style. It is also helpful if the teacher can meet with the student to gain information about his preferred subjects and interests, to help in lesson planning, and to jointly find ways to assist the student in successful task completion. The classroom teacher, with the assistance of the learning specialist and/or principal, should develop a "Student Progress Sheet" so that the student can record his grades, tasks completed in the classroom, and homework. This report should be monitored weekly by the classroom teacher and shared at subsequent Student Study Team meetings.

Mrs. H, Henry and I then met with his new teacher and we devised a "return to school" plan. During the first week, Mrs. H would accompany Henry to his classroom but stay in the back until recess. At this point, the teacher would walk Henry out to recess and be his "transitional" object. I asked the teacher if there were any children in the class who might be able to respond supportively to Henry and include him in their activities. I noted Henry's interest in trains and airplanes and the teacher was able to identify another student in the class with similar interests. Thus, during this first week, the teacher
engaged both Henry and this other student (Robert) in conversations about trains during recess. Although Henry continued to be distressed about his mom's absence following recess, he did stay at school all week. He continued to complain about stomach aches in the morning but he was less resistant to getting ready for school.

During the second week Mrs. H stayed only for the first 45-60 minutes and, at the teacher's signal, left. The teacher would signal Mrs. H to leave at a time when she was able to be close to Henry's desk so she could again be the "transitional" object. The teacher would then walk Henry out at recess (preferably with Robert also) and tell Henry where she could be found if he needed her. During the third week, Mrs. H would take Henry to school but leave as he entered the classroom with the teacher.

An important part of this intervention was to coach Mrs. H on how to deal with Henry each morning. She was instructed to respond to his functional needs (getting dressed, getting breakfast, and so forth) and clearly state "I want you to go to school today". She was to ignore his complaints and at the end of each day when she picked him up tell him how proud she was that he was going to school. Knowing how difficult it was for her to deny Henry anything (in this case refusing to let him stay home), I told her that I would check in with her at a certain time for 5 minutes during the first three weeks. During those calls I would say something like: "I can understand that you are questioning if you are doing the right thing and are worried that Henry might become angry at you."
As you and I have talked before, Henry will be much better off in the long run if he has an education and can manage on his own. Going to school will help him later when he is ready to find a job. You are being a good mother even though it feels hard right now". Mrs. H's involvement in this "return to school" plan seemed to help her gain a sense of empowerment. I later learned that Mrs. H developed a good working relationship with the teacher and would frequently talk to her about Henry's progress. This was also facilitated by the school's efforts--they placed Henry with a teacher who spoke Spanish, invited Mr. and Mrs. H to observe the classroom whenever they wished, and conducted testing to evaluate more formally Henry's educational needs.

Mrs. H's issues with boundaries became apparent in her frequent distress calls to me, which were often peppered with "I'm really sorry to bother you doctor". I was faced with needing to balance the issue of limits and boundaries with availability and support. My compromise was to acknowledge my inability to continue responding to the calls but indicate that I could see them twice a week instead. This turned out to be an excellent solution since it seemed to provide Mrs. H with a greater sense of security and continuity from session to session. I surmised that knowing she would see me in a few days made it more possible for her to contain her anxiety with Henry and she could let it out with me in session.

Mrs. H's improved relationship with bureaucracies (including the agency and the school) made her less suspicious and distrustful of her environment.
Her decreased anxiety about the "malevolence" of others was conveyed to Henry by her attitude--she was able to send him to school and let him know she believed the school could provide adequately for him. This change came, of course, later in the therapy process.

Intermediate treatment goals were pursued in the following ways. As therapy progressed and the intensity of Mrs. H's feelings about her deceased daughter, her parents' giving her away as a child, Henry's safety and so forth subsided somewhat, we began to focus on her marriage. I invited Mr. H to the sessions and we were able to arrange times so that he could come occasionally. The "mother only" segments during these times became devoted to couple issues with encouragement for greater sharing both as a couple and as parents. Mr. H was very responsive and felt that Henry had usurped his role in his wife's affections and he wanted greater intimacy and privacy. He also felt that his wife was unable to discipline Henry but undermined him when he did. We discussed these issues and tried to develop a strategy on how discipline would be handled.

In my individual sessions with Henry, we began to talk more to each other. I often asked him about his interests, whether he had made any friends at school and about wishes/dreams he had (for example, "If you could wish for any three things, what would they be?"). I paid close attention to his nonverbal language and at times would make what I thought he was communicating overt (for example, I might ask, "Would you rather play alone right now?"). During
one memorable session, Henry was lying on the floor and playing with two action figurines. Suddenly, one of the figurines said (Henry doing the talking for each figure, in Spanish) "I don't want to play with you anymore." The other figure then doubled over and said, "When you say that you hurt me so much. Don't you know that you are my best friend?" At this point, Henry stopped and seemed frozen. His eyes filled with tears. I moved closer to him and said, "People can do different things and have different interests and still care about each other."

During the family segment that followed, Mrs. H stated that Henry had been rude to her earlier in the week and had yelled that he hated the television program she was watching and wanted to do something else. She reported that she got so upset by his tone that she went to the bathroom and threw up. She then told him how his rudeness made her sick. Henry had, for the rest of the week, been subdued at home but she wished he would always behave himself. This event illustrated so powerfully the conflict Henry was faced with: expressing his differences with his mother would make her sick—he needed to contain himself and follow her lead if he wanted her to be healthy. My intervention was to have Mrs. H acknowledge that Henry was not responsible for her physical illness and that he did not have the power to control her health. I also noted that Henry's interests did not have to match his mom's for him to love her. I tried to elucidate for Mrs. H the powerful (but negative) impact this event could have on Henry—that it could make him afraid to express himself to
develop his own interests and to become an independent, assertive human being. I acknowledged that Henry may need to learn how to express himself in an assertive and nonaggressive manner. We spent the rest of the session focusing on this issue of being separate (having separate interests, needs, etc.) but still being connected. I tried to help each identify likes and dislikes and worked to highlight how the differences here made them no less caring about each other. Henry was encouraged to develop his own set of interests, some of which might be similar to mom's, some to dad's, and some to none of them.

I monitored Henry's school progress during the first month of his return to school by making a weekly call to his teacher. After the first month, Henry was attending regularly although he now showed some dependence on the teacher and was only slowly developing age-appropriate relationships.

Long term treatment goals were pursued as therapy progressed. I continued to work with Mrs. H to help her understand that in order for Henry to function in a better way, she needed to express to him that she believed that he was capable of doing things for himself and by himself, and that she could function in the world without him. To accomplish this, the mother needed to begin to believe this herself. She needed to establish relationships in which she could share the details of her physical problems and her fears about them without threatening the security of Henry's world. This could be accomplished by sharing these concerns with her husband (which might strengthen the marital alliance) and by developing a support network with other adults. The
possibilities included strengthening relationships with members of her extended family, making friends with neighbors, joining support groups, or getting more involved in the church. I hoped that by giving Mrs. H some individual time in session, she could begin to explore her own issues, resulting in some relief of her depression and anxiety. Mrs. H's increasing comfort and sense of effectiveness and security within her environment could then set the stage for Henry's beginning to feel more comfortable about exploring his own world. He could then be more comfortable in establishing new relationships which did not include his mother, without feeling guilt. Mrs. H had become the center of Henry's world and vice versa. Henry needed to hear that his mother could fend for herself without him, and that she supported his exploration of that part of the world which did not include her.

In addition, I sought to help Mrs. H feel more confident in herself and comfortable in her requests of Henry and others, including her spouse and the school. I wanted her to feel empowered enough to make honest requests, and to have the expectation that others might comply with those requests. She had difficulty communicating clearly and giving direct instructions about what she wanted. Speaking firmly with conviction would help give Henry a model of assertive communication and would likely be rewarded by increased compliance. I had concerns that if the mother was not effective in communicating her own needs, she might express her anger in a passive-aggressive way. Thus, an additional aim of therapy for the mother was to help
her become more assertive, to express herself more clearly, and to identify her needs to develop her own interests with the hope that this would help her feel more powerful and able to cope in her world.

Mrs. H decided to take "English" classes through adult education. Her success here prompted her to seek assessment of vocational interests with the goal of obtaining some training so she could develop marketable skills and eventually contribute to the family's finances. She was enlivened by this process and even became an active member of the PTA at Henry's school.

In our individual sessions Henry and I began to address more overtly the bind he had been in--that if he developed as a separate, autonomous being he would hurt his mother and ultimately fail anyway since he was weak and the world was dangerous. We did this as we built model airplanes or played with train sets.

I was hopeful that in therapy Henry would, in addition to identifying dreams for the future and interests he could engage in in the present, show increased initiative and assertiveness. I asked him if he would be interested and willing to play a modified soccer game in the office. For several weeks we would push the furniture to the side and establish the game rules. As we played, I would verbally cheer Henry on as he tried to get the soccer ball away from me. I would then draw connections between our play and the outside world--that when Henry very much wanted something (like he did when he was trying to take the ball away from me), he needed to be able to "challenge" and
go for it assertively. Similarly, when he had something that he wanted to hold onto, saying "no" and keeping it away and to himself (just like he fended me off from taking the soccer ball) was not "hurting" anybody. We also talked about how this was a necessary part of learning how to get along with and grow up to be as strong as other boys in his class, which Henry wanted to do.

Henry was in the process of changing from a passive and angry child to one who was more assertive and confident. He told me that on one occasion a kid had pushed in front of him in the class line and Henry had told him not to and took his place back from this kid. Henry had also begun asking his father if he would play soccer with him and they had begun doing this several times a week. I enjoyed hearing how Henry wanted to repeatedly engage his father in the same "challenge the ball" exercise that we had been practicing in my office. Henry seemed to relish being able to be so asserting and challenging with his father in this physical way, and equally delighted in seeing his father's determination to protect the ball. Some of the neighborhood kids had also begun to join Henry and his dad and Henry had been invited to one of those kids' birthday party. To further these important gains, Henry's parents were encouraged to involve Henry in a city soccer team where Henry could be involved with and succeed with other boys his age.

Mr. H continued to attend the sessions as his time permitted. I discouraged Mrs. H from letting Henry sleep with her and encouraged her to make an alternative sleeping space for Henry that was as pleasant as possible.
For example, I encouraged her to let him have a "train" night-light, if possible buy him a quilt with airplanes or trains on it and so forth. Mr. H was very much in favor of this and even worked an extra shift to purchase these items!

Mrs. H's fear of Henry's anger and possible rejection if she was firm with him was directly addressed. This process was reframed to make her see how, at times, painful or difficult processes were very necessary for good outcomes. I used the example that for her to get her gallstone problem healed she would need to go through treatment—which would likely be painful or difficult, but that the treatment was necessary for her to get fully healed.

Thus, appropriate family roles became focused on more as time progressed. Mr. and Mrs. H were coached on parenting issues (implementing a time out program; withdrawing certain reinforcements when Henry acted out, rewarding him for appropriate behavior, giving him clear and unambiguous directions about what was expected of him and so forth). Mr. and Mrs. H were also encouraged to discuss their differences about parenting in privacy and not allow Henry to manipulate them based on these differences, as had occurred in the past.

Termination was addressed when Mr. H found a job with medical benefits in an adjoining city. The family realized that they still needed to be in therapy although their overall functioning was significantly improved. We thus agreed to schedule once/month sessions until they connected to a Spanish-speaking therapist in the new city. I was able to support them psychologically.
as they made the move and Henry's teacher and school psychologist were very helpful in facilitating his transition to the new school. Although Henry complained of stomach aches the first week at his new school, these complaints had all but disappeared by the time I saw them a month later. Probably the most important factor in adjustment was his mother's improved mental health and her unambiguous statement that she wanted him to go to school and believed that the family and school could together resolve any issues that might arise.

Revision of treatment plans was necessary as therapy continued and took form in the following ways. Although working with the whole family had been helpful, I felt that Mrs. H needed more individual therapy than our sessions provided since a large focus of that was related to Henry. When the family re-located toward the end of therapy, I was able to find a female therapist for Mrs. H and a male therapist for Henry. I saw the family once after they had moved primarily to get closure and verify that the transition was relatively smooth. I had two phone contacts with Mrs. H's and Henry's new therapists. Mrs. H seemed to be using her individual therapy well and was processing further the loss of her daughter. She continued to work on learning English and planned to follow through with her vocational interests.

Henry became very involved with a soccer team and his success as a "strong player" on the team was helpful in developing several friendships. He complained about the impact of therapy on his parents--he was often not
pleased about the firmer, more consistent family rules and the stronger coalition between his parents but his feelings about this became less important as he engaged in more age-appropriate relationships.

The reality of Henry's world was that it was potentially violent and dangerous. I had to evaluate the contribution of realistic fears to his symptoms but be careful in addressing these and finding ways to increase his actual safety (e.g., being accompanied to school by a parent, not playing in parks known to be frequented by gangs, and so forth) that I did not inadvertently contribute to his perception of the whole world as dangerous and thereby increase his separation fears. I was careful when discussing realistic dangers in his environment to emphasize that this did not represent the whole world.

Although encouraging assertive self-expression in Henry was a reasonable goal, I had to be careful that this goal did not violate culturally sanctioned humility, especially in regard to interacting with elders. I always emphasized that one could be both assertive and polite and give examples of how that might be expressed (e.g., "May I have the chance to choose a TV program today?", versus pouting but not expressing an opinion or angrily demanding to be allowed to choose a program). Henry's style had been to pout when things were not going his way and this "passive-aggressive" style frequently worked with his mother who would then give in, exasperated. I pointed out how much unpleasantness this raised for both of them and that learning assertive negotiating skills would serve them both well.
Another major balancing issue concerned Mrs. H—her history of disrupted relationships made it important that I be consistently present for her. However, her difficulty with maintaining boundaries made it important that I model being separate and boundaried but still connected. Her frequent calls in the early stage of therapy made this issue critical—my solution was to be available to her more frequently (twice a week) but limit contacts between sessions (thereby maintaining that boundary).

Seeing Mrs. H, Henry, and the whole family was at times strenuous. I had to be extremely careful about sharing information from individual segments in the family segments (although I did obtain Mrs. H's permission to bring up things from her past if they were relevant and useful in the family segments). In addition to managing the issues between the family members I had to be an alert time manager. This was especially difficult with Mrs. H in the beginning whose need to be heard was at times overwhelming.

I was aware that the therapeutic process would include relational reenactments of historic relational patterns which would require a "better" response from me. Some of these reenactments involved Henry's mother. Mrs. H's tremendous need to be heard and responded to was evident in the way she drew my attention by her dramatic stories. It was often difficult to end the therapy segments with her in order to meet with the whole family. The way in which I felt compelled to respond to her and at the same time overwhelmed by her gave me a sense of how Henry must experience her and the burden and
guilt he must experience daily. I often found myself verbalizing what I perceived to be mom's needs: "It sounds like you have so much pain and at times feel desperate to be heard". She seemed to find this reassuring and it seemed to assure her that the emotions below the words were being heard and responded to.

Mrs. H's difficulty with setting limits was evident in her requests to me to tell Henry to do his homework and other requests that I assume the authority/parental role with Henry. I suspected, however, that if I had responded to these requests I would have been viewed as father was—harsh and stern. This would also have provided Mrs. H and Henry with another "enemy", further strengthening their unhealthy alliance. Thus, I consistently emphasized my view that she was Henry's parent and that teaching and supporting her in setting limits was the best long-term solution. I was then available to help her process the impact of Henry's anger at her. I was also able to highlight for her how her appropriate limit-setting was contributing to Henry's social and academic progress (he was completing tasks more and learning interpersonal negotiating skills).

Henry did not like his mother having private meetings with me and would often pout and knock on the door, especially in the early part of therapy. Mrs. H's response was to smile and say she knew Henry would not be able to be away from her. She seemed to reinforce this behavior by almost lovingly telling him he needed to wait outside and suggesting that I wanted this. I asked Mrs.
H if she wanted Henry to be with us during these sessions—which she denied—and I tried to gently show her how confusing her message could be to Henry. Helping her realize the ambiguous quality of her messages and their potential impact was useful. We then agreed to give Henry a timer and told him not to knock until the timer went off. I surmised that Henry's behavior was similar at home and robbed his parents of privacy. I was also aware of being irritated at Henry and feeling as though we were "competing" for Mrs. H's attention. I realized that this was indeed how Henry and his father related to each other and felt that helping the family define roles more clearly and the need for privacy was critical. Thus, in the family sessions I encouraged Henry's parents to block out time when they could be alone. I then acknowledged overtly to Henry that he might have negative feelings toward me for making this suggestion and invited him to share these with me. During one individual session, after Henry's parents had implemented my suggestion, Henry had difficulty containing his anger at me and yelled, "I hate you, I don't want to come here anymore", and used several foul words. I let him know that it was okay to be angry at me and to tell me that but use of foul language was not okay. I then continued to be engaged with him, asking him if he wanted me to join him in the game he was playing or not. I believe that my ability to set limits (regarding the foul language) but remain engaged was a critical turning point. After this, Henry began to act out much of his anger in his play (cars crashing, action figures fighting and so forth). Over time this play became more
controlled (the cars would, speeding toward each other, say "watch out" and not crash; the figures would help each other build their armies and discuss strategy for beating the other side). By this time Henry was including me in his play more consistently and I had the opportunity to suggest alternative strategies for "winning".

Henry's initial therapy behavior, passive disinterest in therapy, was a result of his undeveloped sense of initiative. Permission and encouragement to explore, to include and exclude me as he chose, and to express his feelings (including negative ones) were significant in fostering initiative in him.

Henry's sense of himself as being a "victim" (i.e., that teachers were unfair and demanding, that father was harsh and stern), which was often supported by his mother, was replayed with me when he accused me of picking on him and making his parents be mean to him. I acknowledged that he might be angry with me but assured him that I harbored no malice toward him. I emphasized that, in fact, I wanted to work with him so he would experience more success and joy at home and at school. Henry was able to grasp this message only as time progressed and gradually he and I began enjoying each other and playing together with more spontaneity and sharing.

There were several impediments to treatment. These included the reality of violence in Henry's community and possibly his school which made me cautious about the extent to which I encouraged Henry's independence and exploration of his world. I often had to distinguish between Henry's realistic and
unrealistic or excessive fears and complaints about school. It is not unusual for children to feel singled out and mistreated by teachers and distinguishing between what was actually occurring and what was imagined was not always easy. The teachers' openness to classroom cooperation and meetings was very useful in this process.

The greatest impediment to Henry's progress was Mrs. H's unresolved attachment issues that made it difficult for her to allow Henry to individuate. Mrs. H needed extensive individual therapy but the language barrier and limited financial resources made it difficult for us to find an individual therapist for her early on. However, I did find my individual time with her useful in understanding Henry and his presenting problems.

Termination came after I had seen Henry and his family for a year, sometimes seeing them twice a week. We terminated after his family moved to a new city, although I did have one final session with them after they moved. Mrs. H had an individual therapist and I suggested that she might benefit from being in a support group for parents who had had a child die such as Compassionate Friends. Although Henry was also connected to a therapist in this new city, the school psychologist had suggested he become involved in a school-based counseling program that included group therapy. The opportunity for increased contact with peers seemed like an excellent one. Henry was also involved in a soccer team and his father tried to attend soccer whenever he could. Mr. H and Henry now had an improved relationship and Mr. H often
"coached" Henry in soccer at home.

Henry and his parents liked the teacher at his new school and Henry was especially fond of the cafeteria food! Although Henry's report card confirmed his improvement, he continued to have some academic deficits and would continue to receive special academic assistance.

Mr. and Mrs. H continued to need help with responding as a parental team with regard to Henry but were showing some improvement. Although Mrs. H sometimes felt guilty when setting firm limits with Henry, she was able to tolerate this better and had a therapist with whom to process the issue. Their marriage was much improved and they were spending more time together.

Clearly, Henry's functioning at school, home and socially had improved. Although he was still occasionally passive-aggressive and resistant to limits, this had lessened significantly.

In some ways I was sad to see them leave at this point just as the major changes in Henry's life (academic improvement, increased social activities) and in Mrs. H's life (greater insight into the genesis of her anxious attachments, vocational goal-setting, and improved social relationships) were occurring. I was pleased that they would continue with therapy elsewhere and felt honored by the trust they had shown by staying in therapy and sharing details of their lives with me.

ILLUSTRATION II - Case Study of Brian

Authors: David Chavez, Ph.D. and Nancy L. Wolfe, M.S.
General Introduction:

Most therapists are likely to treat Conduct Disorder, since one third to one half of all child and adolescent referrals involve conduct problems, aggressiveness, and antisocial behavior (Wenar, 1994). According to DSM-IV (American Psychiatric Association, 1994), prevalence estimates suggest that this disorder may occur in 6-16% of the population for males under the age of 18 years, and 2-9% for females in that same age range. The criteria for a diagnosis of Conduct Disorder, as established by the DSM-IV, state that Conduct Disorder is typified by "a repetitive and persistent pattern of behavior in which either the basic rights of others or major age appropriate societal norms or rules are violated" (DSM-IV, p.85). According to DSM-IV, three behaviors, from any of the four main groupings of behavior, must have been present in the last twelve months, with at least one present within the last six months for a person to receive a conduct disorder diagnosis.

Aggression to People and Animals:

(1) often bullies, threatens or intimidates others
(2) often initiates physical fights
(3) has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)
(4) has been physically cruel to people
(5) has been physically cruel to animals
(6) has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
(7) has forced someone into sexual activity

Destruction of Property:
(8) has deliberately engaged in fire setting with the intention of causing serious damage
(9) has deliberately destroyed others' property (other than by fire setting)

Deceitfulness or Theft:
(10) has broken into someone else's house, building, or car
(11) often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)
(12) has stolen items of nontrivial value without confrontation of a victim (e.g., shoplifting, but without breaking and entering; forgery)

Serious Violation of Rules:
(13) often stays out at night despite parental prohibitions, beginning before age 13 years
(14) has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)
(15) is often truant from school, beginning before age 13 years
Additionally, the disturbance in behavior must cause significant impairment in social, academic, or occupational functioning. Individuals who are 18 years or older and who do not meet the criteria for Antisocial Personality Disorder can still be diagnosed with Conduct Disorder.

The DSM-IV makes a distinction between Childhood-Onset Type, in which at least one criterion characteristic of Conduct Disorder is met before age 10, and Adolescent-Onset Type, in which none of the criteria is met before age 10. In a majority of individuals, there is a reduction of symptoms by adulthood. Early onset however, as in the case of Brian, can be predictive of poorer prognosis and increased risk of adult Antisocial Personality Disorder or Substance-Related Disorders.

According to Wenar (1994), these are two sub-groups of Conduct Disorders. The first is the undersocialized or solitary aggressive type, which is defined by fighting, disobedience, temper tantrums, uncooperativeness, impertinence, and restlessness. These individuals are typically aggressive, impulsive, fail to learn from experience, and lack feelings of guilt or anxiety. This subtype is considered to be the most severe type, with poorer prognosis including greater likelihood of Antisocial Personality Disorder and Substance Abuse Disorder. Brian was a child who fell into this category. Therefore, early intervention was extremely important in order to avoid the possibility of such an extremely negative outcome later in his life.

Children and teens who exhibit the other cluster of behaviors have been
termed socialized or group aggressive type or delinquents. Typical behaviors for this group include having conduct disordered companions, being truant from school and home, being loyal to delinquent friends, stealing with others, lying, and fire setting. This group has been socialized with a deviant set of values and typically comes from lower socioeconomic level homes. It is especially important when working with children and adolescents from different cultural groups to assess the extent to which behaviors exhibited by these individuals are due in part to environmental factors since it is not uncommon in some places for individuals to be threatened with physical harm if they refuse to join a gang and engage in activities of this sort. Understanding the environmental context can have significant implications for intervention.

These sub-groups (undersocialized/aggressive and socialized/group aggressive) are not included as sub-categories of conduct disorder in DSM-IV, but still aid in helping clinicians make distinctions that might be useful in understanding development of problem behaviors and differential treatment outcomes.

Wenar (1994) notes that in normal development, socialization and the development of self control are facilitated when secure attachment and basic trust are formed between the child and the primary caretakers. These caregiving relationships, based on affection and nurturance, become the most important part of the child's developing world. Keeping these secure ties intact is of primary importance for normal development. When the parent-child
relationship develops normally, the child internalizes the parent's rules and loving feelings for the child, and the capacity for empathy and sympathy become possible. This reassuring and responsive relationship allows the child to form a link between parental directives and the feelings of affection that bond the relationship between the child and the primary caregivers. As this occurs, the child moves away from his or her egocentric perspective and becomes willing to forgo his own impulses and incorporate or take on the perspective of the parent. It is in the context of this stable, consistent and trustworthy relationship that children can learn what is expected of them, how to attain goals, and develop strategies for delaying gratification in order to gain social approval. In order for this to be possible, the child's memory must become sophisticated enough to remember the socialization messages that the parents give, which occur progressively through the toddler and preschool years. Thinking must also develop so that the child is able to move from literal interpretation of messages to more the abstract, allowing generalization from one situation to the next.

In the child with Conduct Disorder, this socialization process goes awry. It has been theorized that for the "conduct disordered child", the primary attachment bond, necessary in the socialization process, is insecure or in some way becomes disrupted. Longitudinal data following children from early to middle childhood supports this hypothesis (Erickson, Sroufe & Egeland, 1985; Renken, Egeland, Marvinney, Mangelsdorf, & Sroufe, 1989). This may be
caused by the mother's inability to parent effectively or it may be the result of a bidirectional interaction between a temperamentally difficult child and an overwhelmed parent. Active, willful, intense boys with a short attention span are more difficult to raise and can be more vulnerable to the stressors of family conflict and disorganization. Waters, Posada, Crowell, and Keng-ling (1993) suggest that even if we cannot trace disruptive behavior problems etiologically to attachment problems, the behavior problems themselves will inevitably disrupt the "secure base" relationship. Regarding temperament, Campbell (1991) also found that certain "difficult to raise" kindergarten children who were aggressive, noncompliant, hyperactive, and inattentive, were at risk for continued problems. Thus, a negative escalating cycle may develop, with the child's behavioral problems persisting, which may then increase stress on the family and the marital coalition and cause conflict in the mother-child relationship. Campbell hypothesizes that stressed mothers become more restrictive and negative in reaction to impulsive and difficult children. The mother's "more stern" reaction is ineffective and only serves to make the child less compliant.

In addition, excessive environmental stressors (i.e. poverty, unemployment, illness etc.) and maternal psychological disturbances (i.e. depression) can weaken the parent-child relationship and put the child at greater risk for behavior disturbances. In a study by Egeland et al (1990), maternal depression was positively correlated with an increase in the child's
disruptive behavior. Additionally they found that if stimulation, predictability, and organization in the home was low, and stressors, such as financial difficulty or illness was high, behavior problems were more likely to occur. While conduct disorders may be diagnosed for children of all social and racial groups, it is especially important in designing treatment plans for the minority child, that the cultural context is examined and that interventions are devised that will be consonant with their specific cultural values. For example, it is important for therapists to be aware of how different cultures express affection and bonding. Further, in some settings, gang members and other individuals whose values differ from those of the mainstream culture may be the primary attachment figures which impact the client's values and behavior. Thus, if the primary attachment relationship is disrupted or is contributing to dysfunction, it is important to provide the child the opportunity to establish a bond with someone who will be sensitive to and accepting of differences in self expression and relating and who will model behavior which will enhance the client's functioning.

The skilled clinician is the person who takes all factors of the client's world into consideration when making a diagnostic assessment and planning treatment, including socio-cultural factors. Even though there may exist some commonalities among clients from certain cultural groups, each client's world view will be sculpted by a unique combination of influences. The case illustration that follows describes Brian, an African American child.
Understanding the cultural factors that may impact the clinical presentation and treatment of African American children will therefore be briefly discussed in this section.

It is critical to remember that not all African American families are the same and that there is significant variation based on family background, economic and social standing, value systems, and the degree of acculturation to mainstream American norms (Allen and Majidi-Ahi, 1989). There are however, some commonalities that are worth exploring when working with African American children that may enable clinicians to be most effective.

We know that African-American clients are more likely to drop out of therapy than White American clients at a rate of 52.1% compared to 29.8% (Sue, 1977). This high drop-out rate may be attributed to many possible causes. One of these, according to Allen and Majidi-Ahi (1989), is the pervasive suspiciousness that many African-American Americans have toward White therapists and White institutions. This attitude seems natural given the history of African-Americans in America, plagued by slavery, deprivation, and discrimination. Racism is something that African-Americans contend with on a daily basis and their caution about White institutions can be seen as self-protective and adaptive.

Furthermore, the psychology field itself has been known to demonstrate a bias against African-Americans by seeing cultural differences as "cultural deviance". Often, clinical diagnoses are further biased by the influence of
social class, and the fact that African-Americans are still over represented in lower income levels in the United States. For example, Hollingshead and Redlich (1958) found that class influenced the severity of a clinical diagnosis, with the most severe diagnoses being given to lower class clients. They also observed that mental illness was rarer for the affluent as compared to the lower classes. These findings suggest not only probable discrepancies in ability to make unbiased diagnoses cross culturally, but suggest that diagnoses and interventions are effected by racial oppression and poverty.

Differences in family structure and socialized gender roles could also lead to misdiagnosis of "abnormality" for therapists who are unaware of cultural variations. Women in the African-American community have traditionally worked in order to supplement the low wages of their male partners. This has meant the development of more flexibility between the roles of males and females and the reliance on extended family for added support (Hill, 1972). Women are often socialized in a way that encourages aggressiveness and assertiveness, while men are encouraged to show emotion and be nurturing (Lewis, 1975). Both of these trends were witnessed in Brian's adoptive mother and father in treatment. The mother was strong and forceful, while the father demonstrated a great deal of gentleness and nurturance. They also demonstrated their ability to utilize these "alternative" gender roles as therapy demanded in order to help Brian. Lewis (1975) also found that African-American families were more likely to share responsibilities and decisions
concerning child care. In a study comparing African-American and White families in the Midwestern United States (Gillum, Gomez-Marín, and Prineas, 1984), African-American families were found to be less likely to express conflict openly, were more achievement oriented, were more likely to have a moral-religious outlook, and were more organized and controlled than White families. These also happened to be some of the differences that Mrs. B, Brian's mother, explained about her family's world view as we worked together to design treatments that would fit them personally.

Other factors that influence the clinician's experience of African-American clients have to do with communication differences. According to Allen and Majidi-Ahi (1989), it is not common for lower-income African-American people to nod or say "uh-huh" when they have heard something. They suggest, that without this information, a therapist might consider a African-American child who sits quietly while being given direction, as "sullen or uncommunicative", when in reality this is a culturally normal manner of relating. Because of this lack of verbal feedback, the therapist may need to rely more on non-verbal information with these clients. These authors also note that it is normative for African-Americans to engage in conversation while engaged in another activity, and that it is not considered necessary to maintain eye contact in the context of the activity. Because of these differences in communication, it is common for misinterpretations and mis-communications to occur if the therapist is unaware of the range of normative responses for any culturally differing group.
Allen and Majidi-Ahi (1989) note further differences that influence the success of treatment for the African-American client. For example, many African-American clients place more value on interpersonal warmth rather than the technical competence of the clinician. This makes it important that therapists establish rapport and a collaborative alliance with the clients in order to keep them engaged in the therapeutic process. Moreover, since African-American client's often belong to a network of extended family members, therapeutic interventions can often be more productive when members of that network are included in therapy and attempts are made to improve the family system as a whole. Furthermore, providing social, spiritual, economic, vocational, recreational, personal, and psychological assistance, rather than individual psychotherapy or pharmacotherapy only, is likely to yield better outcomes. Flexible knowledge of community referrals, along with creativity and sensitivity to individual needs, is therefore critical in helping clients from many non-mainstream cultures.

Thus, it is important that therapy begin with the assessment of the client's unique world view. One way that counselors-in-training can do this is by beginning to ask clients about the ideas, values, and goals that they view as most important to them in their lives. Armed with this information about the client's world, the therapist can help the client brainstorm about options for problem solutions that fit the client's personal value system. The therapist can work with the client to clarify the problems and the direction of therapy best
suited for that person in that context. The client then has the choice of choosing the solutions that best fit their lives from a custom designed menu of possible solutions collaboratively discovered by the client and the therapist together.

**Case Illustration II**

Brian was a ten year old African-American child who was brought into therapy by his adoptive mother. The relationship between Brian and his parents was conceived one Sunday morning in church. On that morning, Pastor A. had focused on the sad reality that too many African-American children were living their entire lives in the foster care system because they were less likely to be adopted than White children. He noted further that many of the African-American children who had been adopted were adopted by White families since there were too few African-American families who were willing to take them. He was concerned about the difficulty these children would have developing a proper racial identity in transracial adoptions and there was consensus among the congregation that same race adoptions were a better option, if possible. Pastor A.'s predominantly African-American congregation was touched by his plea for more African-American families to adopt these unwanted children. In the weeks that followed, some members of the church actually began to organize a formal church project that aimed to give some of these unadoptable children permanent homes with members of their congregation. Mrs.B and her husband, who had always been strongly affiliated
with the church, were emotionally touched by his adoption message, and sought to follow Pastor A.'s plea to rescue children in need of a home. In their desire to meet their Christian ideals, they started adoption proceedings. The adoption process was time consuming and complicated, but Mr. and Mrs. B were tenacious. After a little more than a year, they were given custody of Brian, age ten, and his natural sister Alisha, age eight. Brian and Alisha were welcomed into a family consisting of Mr. and Mrs. B and their biological son, Nathan, age eleven. The couple was hopeful that they would finally be able to provide these children with the loving home that they had always missed.

The family didn't know much about the background of the children, other than the fact that there was a history of drug and alcohol abuse in the natural parents of the children. The children had been placed in foster care when Alisha was an infant and Brian was about two years old. Neither child remembered their biological mother or father and had lived in a series of foster homes since their removal from their natural parents. Not much was known concerning the conditions in the previous foster care placements, other than the fact that one set of foster parents with whom Brian and Alisha had lived were currently being prosecuted for sexual molestation of several other children who had been placed in their care. There was a strong suspicion that Brian and Alisha might also have been victims of this foster family's sexual abuse.

Brian was brought into therapy because he had begun seriously acting out since being placed with his newly adoptive family. The primary concern
was that Brian had begun to molest his sister shortly after the children moved in. To Mrs. B's knowledge, this had occurred three or four times. However, Brian had also behaved in a sexually inappropriate way with Nathan. Mrs. B reported that she had caught Brian "doing things" to Nathan but was so offended and embarrassed by the behavior that she was unable to go into detail about the acts. She also stated that Brian was physically confrontive with Nathan much of the time. In addition, Brian had been discovered stealing tapes and other possessions from Nathan's bedroom. He had even tried to sell Nathan's bike to another kid down the street. According to Mrs. B, Nathan was a quiet and passive boy, and didn't know how to handle Brian's aggressive acts and she was seriously alarmed with Brian's behavior and the extent to which it was making her biological son's life miserable. Mrs. B also complained that Brian was never compliant with her requests. He was also noncompliant at school and had engaged in fights on the playground. She noted further that sometimes Brian would be out in the yard just talking to himself and that she was worried that he was "just plain nuts".

Brian had also become identified as the "problem" in the neighborhood. For example, he had been throwing rocks at neighbors' windows and at passing cars. He would defecate in the flower bed, then when neighborhood children would come by, he would pick up his own feces and chase them around with it.

At the time Mrs. B first came in, she wanted to explore with me the hypothesis that Brian might truly be psychotic, in hope that she might be able to
undo the adoption arrangement. I explained that since the agreement was already final, returning Brian on the basis of him being somehow "defective" was not a likely possibility. We ended up discussing this hope several more times in therapy before we moved into exploring ways to facilitate Brian's adjustment. I could understand how Mr. and Mrs. B's idealized idea about adoption had been truly shattered. By the time Brian was brought into therapy Mrs. B was indeed very disillusioned. This was not the child that she had dreamed and hoped for and I could empathize with her feelings of regret regarding their decision to adopt him and I conveyed this to her. My empathy and non-judgmental stance were critical in developing a relationship with her. Once she had realized that she could not "return" Brian, her tenacity and creative problem solving skills became strengths which contributed to Brian's eventual adjustment.

Brian was a good looking child of average height and weight. He always came neatly groomed and well dressed. He appeared to be racially mixed, with both African-American and Euroamerican features, but since we had very little information about his heritage, it was difficult to assess what his genetic combination might have been. Brian presented as a quiet sullen child, who maintained an initial aloofness which made sense given the tremendous rejection and lack of stability that characterized his early life. Although polite, he rarely initiated discourse or play in the early stages of therapy.
The family lived in a predominately White neighborhood. They maintained ties to the African American community through their church, which was outside their area of residence. This same-race contact was extremely important for the family since they felt that cultural values and practices between their own race and the mainstream majority culture were quite different. The mother verbalized how these differences were very apparent in parenting practices between African-American families and families of other races. For instance, Mrs. B made it clear that she believed it was normal for African-American mothers to spank their children. I knew from research and experience that, for some groups, corporal punishment was normative. Speaking in a manner which did not challenge her cultural beliefs, I listened to her stance on spanking but expressed the hope that we could identify a range of interventions that might prove effective for Brian. I also mentioned that spanking in anger could become dangerous and out of control. I also expressed that the other major downfall was that it signalled which behavior to stop but did not teach alternative behavior. These became areas for further exploration later in therapy.

At this initial meeting, I needed to let Mrs. B know, in a way that would not alienate her, that by law, I would have to report to Children's Protective Services if I thought Brian was being physically abused. I knew I would be in a difficult position if I were faced with having to report, because if indeed the mother would be found to be abusive, Brian would once again be without a
family. Given Mrs. B's fantasy about "returning" Brian, this felt like an extremely dangerous issue and I was concerned that she might consider this one tactic to rid herself of Brian. I emphasized that if it came to this, CPS was likely to remove all three children. I hoped that Mrs. B would not consider this option, because I believed that the best hope for Brian would be to keep him in therapy, and help the family learn more effective parenting skills. I hoped for those reasons that I would not have to report to CPS, but I also knew that I would report if I found out that Brian was currently being hurt. Fortunately, although Mrs. B believed in firm and sometimes stern discipline, she was not abusive.

During the initial session, I saw both Brian and his mother separately. I interviewed his mother first in order to get an idea about Brian's background and problems from her perspective. Mrs. B was a tall, large-framed woman who was slightly overweight. She worked as a teacher's aide in the public schools and always came to session neatly groomed in attire that would have been appropriate for her occupation.

Mrs. B made it clear to me that she and her family felt strongly linked to their cultural identity as African-Americans. Because of this, she reported that she was very skeptical about whether I, a Latino male, might be able to help her and Brian in therapy. She wondered whether I could understand her way of parenting and her cultural values, which she assumed were different from mine.

It has been my experience with clients of color that many assume that
regardless of race, therapists are members of an institutionally racist occupation and may have difficulty honoring their cultural values. In Mrs. B's case, she stated clearly that she was skeptical of mental health institutions' ability to find viable solutions for her or other African-American clients. She described her previous therapy experience with a white female who had insisted that the family try interventions that were totally incompatible with their value system, such as having family meetings to decide the rules that would exist in the house. These discussions sensitized me to Mrs. B's need to be heard, have her viewpoints acknowledged, and have therapy develop in a highly collaborative manner. Clearly, we would need a solid, trusting relationship and interventions would need to be presented as suggestions with all "demand" or "authoritarian" qualities greatly reduced.

In our initial meeting I assured Mrs. B that even though I myself was not African-American, my goal would be to explore the family's personal values and help them find solutions or options that would fit them personally. I also assured her that it was not my purpose to impose my personal value system upon her and her family. I told her that I was aware that some of my colleagues had very specific "cookbook" values about child rearing, but I realized that often these approved formulas don't fit African-American or Latino families. My response must have been reassuring enough because she responded in a positive manner, and was engaged enough to proceed with therapy which would last for the next 11 months.
The early stages of therapy were difficult in that Mrs. B wanted quick solutions but was hesitant to implement the behavior modification plans which started by changing one behavior at a time. She would state, "I don't think you understand, this may work well for White families, but it won't work for us." I maintained a supportive stance and would then explain, "I have respect for what you're telling me, but in order to help you, we have to find some common ground. These are interventions that have worked for individuals from many backgrounds." I would then address each behavior and intervention, query if and how it violated any personal and cultural value, and then proceed with the intervention after asking her if she would be willing to try it for a specified period of time. I assured her that she didn't have to become White to accept these interventions, and we could modify those aspects that she found offensive so that the changes would fit for her as an individual and as an African-American.

In my individual time with Brian, I found him quiet and sullen, but relatively cooperative. When I asked him why his mother had brought him to therapy, he told me that he did not act "good" at home because his mom made him mad. Brian was unable to articulate exactly what she was doing to create this anger in him. I asked him about the rules in his new home and he reported that he didn't know exactly what the rules were and this was confusing for him. In the weeks to come we would work toward clarifying those expectations in combined sessions with Brian and his mother.

As the session progressed, Brian continued to be quiet and sullen. He
seemed suspicious or distrustful of this new experience he was now being thrust into. I tried to make him feel at ease as I told him how the therapy would work. I told Brian that we would be talking together, and playing together, and I would see if I could help him and his family get along better. I showed him around the playroom, allowing him to get a look at the selection of toys available. As we went through each section of the room, from one toy to another, he would examine each item, quietly manipulate it, then put it back in its place. We made a tour of the room, and I told Brian that if he wanted, we could start playing today. In a somewhat sullen voice, he replied that he would wait until next time. I got a sense that he felt intimidated by this new place. I imagined that I was intimidating too. I am a big man, had a large beard, and given his possible molestation, it was possible that adult males might induce considerable fear. I knew it would be important to be quiet and gentle in therapy with Brian, letting him make the choices about how fast to go in this new arena. I felt that this was especially important given his lack of choices and history of being disempowered as a result of frequent foster placement changes and probable sexual molestation.

Even though Brian most clearly met the DSM-IV criteria for Conduct Disorder by his sexual perpetration, physical aggression and cruelty, and petty thievery, I also suspected that depression and anxiety might be underlying issues, perhaps fueling his acting out behavior. I also did not rule out the possible contribution or interaction of Post Traumatic Stress Disorder,
considering it's common occurrence in sexual abuse survivors. However, I believed that to a large extent Brian's caution and fear also stemmed from his horrific experiences with the bureaucracy associated with the social welfare system and his history of rejection and abuse by adults. I was an adult, and I worked for what he might have perceived as one of the institutions that had failed to protect him and care for him. It would be my job in therapy to prove that I was not another exploitative person and that I could offer him caring and support following his victimization, something different from his previous experiences.

As I attempted to conceptualized this client, I realized that while there were a multitude of issues that needed to be addressed in this case, three main points served as organizing principles in the formulation of intervention with Brian: 1) issues of rejection and abandonment in Brian's life; 2) the issue of sexual abuse - both its perpetration by Brian, as well as his probable victimization; 3) the need to intervene with his adoptive parents to increase both their levels of nurturance as well as effectiveness.

Addressing feelings of rejection and abandonment was accomplished in the following ways. Brian had lived a life in which each day reminded him that he was somehow unlovable, inferior, and worthy of rejection. From his point of view, he had been rejected by his natural parents, since they were unable to care for him. Internally, he might have wondered why he had been born into a world with parents who were so unfit and cared so little for him that he was
taken from them. Feelings of rejection and abandonment were intensified by being tossed from one uncaring, emotionally disconnected foster family to another. And finally, upon adoption, it seemed that even here he would not gain the approval of his adoptive mother, no matter what he did. Brian's racial identity may have exacerbated his experience of being unworthy since members of the majority culture sometimes devalued people from his racial background.

It all seemed so unfair, and out of his control. He had been helpless from the beginning, powerless to make any decision that really mattered in his life. The only thing that would be clear for Brian was the fact that he had never been nurtured and loved, that people treated him as inferior, and that he had endured one rejection after another as he bounced from one foster home to the next. These experiences contributed to his perception of himself as defective. I hypothesized that Brian's acting out provided him with a sense of control and power, by providing a justification for the rejection he had experienced and the abandonment he anticipated from the new family. His acting out was thus a defense against his powerlessness in the face of frequent abandonments and possible sexual victimization. This defense represented an attempt to impact the outcome of the adoption which he expected to end in rejection and removal from the home.

Brian had come to view the world as an unpredictable place, and all decisions important in controlling the pain in his life were out of his control. So
Brian seized power in the small ways that he could. He was stuck with a dominating adoptive mother, so Brian controlled by ignoring her and failing to comply with her demands. He attempted to take "power" in the relationships in which he was able to dominate, molesting his sister Alisha and abusing his more passive adoptive brother, Nathan.

Brian identified with the aggressors in his life and his destructive acting out was a manifestation of this identification. I suspected that Brian's history of disrupted attachments robbed him of feelings for his victims. Further, since so many of the events in his life occurred without regard to his needs, and he did not have the power to remove himself from his life of pain, he "seized" power by inflicting pain upon those less powerful than himself. Thus, the issues of rejection and abandonment were interconnected with the second issue of sexual abuse.

There was also a need to address the abuse which had occurred in Brian's life. Because of the drug and alcohol abuse history of his natural parents, it is doubtful that a secure attachment had been formed between Brian and his mother, even though he reportedly lived with her for two years. Regardless of the quality of that relationship however, whatever attachment had been formed was disrupted when the children were pulled from the mother's custody and put into foster care. The foster care homes that followed were numerous, and even if the children started to become attached to a foster family, that was destroyed by the frequent custody changes. Not only were
these relationships brief and disrupted, but if Brian had been molested as suspected, he would also come to know the nature of his relationships with adults as frightful, hurtful, and dangerous. Through his life experiences, which appeared to also include molestation, this young child had come to know the world as a dangerous and unpredictable place. He had come to be distrustful of adults, and guarded about getting emotionally attached to anyone, since it would only end in the sorrow of separation or abuse. He learned that he could not trust or rely on anyone in the world but himself. He learned that even to rely on himself alone was a dangerous position, given the fact that he had power to change very little in his world of pain. This lead him to control and inflict pain on others, as a way of dealing with his own pain.

Finkelhor and Brown (1986) write compellingly about the impact of sexual abuse and note that it can result in traumatic sexualization, a sense of betrayal, feelings of powerlessness and stigmatization. Brian's history, including his probable sexual victimization, had left him feeling ineffective and powerless. He had no consistent advocates and had experienced betrayal first by his biological family and later by the system that was supposed to care for him but had placed him in homes where he had been victimized. Finally, if Brian had indeed been sexually abused, his concept of sexual activity would have been shaped by this experience. Brian, for instance, may have come to see sexual contact as one way to be in control of others and to get them to respond to him.
Increasing parents' effectiveness and nurturance was another important goal. Brian's adoptive parents consisted of a controlling mother and an adoptive father who took on few parenting responsibilities. Brian thus lacked any warm or affectionate attachment to an authority or parental figure, something necessary to internalize and follow through on rules and expectations. He responded to his adoptive mother's attempts to control him by being non-compliant and by acting out in ways that would distress her (e.g., attacking Nathan or Alisha, or defecating outdoors). In this way he was not completely under her control nor was he completely powerless. Her expectations of complete obedience and his disempowering life experiences were fuels for his acting out. Brian's adoptive father's minimal parenting in the early stages of therapy may have represented "emotional absence" which had also characterized many of his foster care experiences. Thus, Brian in his new home, was faced with two parents whom he may have seen as either unresponsive (father) or controlling (mother). Further, as is often the case with children with conduct disorder, the parents appeared to lack an effective strategy for disciplining Brian and for providing for his emotional needs. Often these two issues go hand in hand, and I believed that providing concrete guidance would facilitate their ability to parent him more effectively (e.g., by setting and enforcing reasonable rules), as well as emotionally connecting with their new son. In turn, I was convinced that helping Brian's adoptive parents learn to empathize with Brian's plight would lead them to develop and enforce
appropriate limits and greatly reduce his acting out. Warm, consistent limits which were clearly identified were, I believed, the key here.

There were several orienting constructs that helped me to understand Brian's case. Brian had been referred to our clinic because of the strong suspicion of sexual abuse from Brian's previous foster placement. This was suspected, not only because of the impending prosecution of the foster family in relation to sexual abuse of other children who had been placed in their home, but also because of Brian's molestation of his sister, and his other sexual acting-out behavior. Such behavior commonly occurs in children who have been molested themselves. This premise helped to organize my conceptualization of Brian's problems and was instrumental in establishing the goal of eventually helping Brian to process the emotional impact that such abuse had on his life. I hoped that eventually he could begin to articulate how that experience had impacted his own life emotionally and how his own sexual perpetration might impact the life of his own victims. I hoped that by developing empathy for himself as a victim, and for his own victims, he would be safe from further perpetration in his life. I also hoped to help Brian find more appropriate ways to express his pain and gain empowerment (i.e., a sense of control and competence) in his life. These issues will be further elaborated in the treatment section.

The other construct that served to focus my treatment of this client is attachment theory and "internal working models". I related to Brian as a boy
who had never had a secure emotional bond with an attachment figure. His own internal concept of himself in relationship to others had been formed by his history of repeated traumatic experiences, and left him with three problematic "templates" for interpersonal relations. Specifically, because Brian lacked a loving relationship in his life, (1) he did not expect or feel he deserved one. Because he was abandoned throughout his life, (2) he expected to be rejected and experienced himself as not love worthy. He thus feared risking emotional commitment in his new home. Because he had been exploited and sexually abused, (3) he was distrustful of others and experienced himself as powerless and shameful. These painful developmental experiences shaped Brian's current, symptomatic reactions to his new family in which he tried to gain empowerment by shaming others. His sexual molestation of Alisha, attempted molestation of Nathan, and public defecation can be seen in this light. Although his behavior made sense given his history, his hostile and provocative behavior was maladaptive and further alienated him from members of his new adoptive family. In treatment, Brian needed to be given opportunities to test new ways of relating that did not fit the three old templates. The challenge was to help him grasp how previous conceptualizations about the nature of the world and relationships accurately fit the past, but may not fit the present. I hoped that if my relationship with Brian could be characterized by warmth, caring, and active engagement, where he was not able to elicit the anger and rejection in me even if my rules were violated, it would help to redefine what human relationships
could provide. I could then in the context of this new kind of relationship help Brian internalize rules and ways of behaving that would enhance his quality of life, especially his relationship with his family. Thus, by not allowing him to re-construct our relationship along the same old familiar and problematic lines, I hoped to utilize our relationship to provide him a new and better solution. In turn, I also aimed to give his family the tools they needed to provide Brian a more corrective experience at home, one that involved developing caring relationships where rules were enforced in an atmosphere of warmth and fairness. My hope was that if Brian and his adoptive family began to value each other, the parents would be willing to invest in the effort that effective parenting demands and he would internalize their rules which would lead to more rewarding family relationships.

My treatment plan was organized across the three conceptualization issues I have addressed earlier: 1) Brian's issues of abandonment and rejection; 2) Brian's sexual molestation; and 3) Brian's adoptive parents' parenting skills.

Short term treatment goals would include 1) Begining to establish a corrective emotional relationship with Brian that addresses issues of abandonment and rejection; 2) Openly addressing molestation issues, including Brian's molestation of his sister and the possibility of Brian's own sexual molestation; 3) Taking steps to stop Brian's molestation of Alisha and begin to work through feelings related to his own victimization; and 4) Developing a
trusting working relationship with the mother. De-escalate the level of conflict between Brian and his mother at home.

Intermediate treatment goals would strive to: 1) Continue to foster trust in my relationship with Brian. Help Brian to clarify what he needs to do in order to be accepted by his new family - What behaviors are expected, and what are the consequences and rewards?; 2) Educate the parents about the normal development of 10 year olds, and common side effects of molestation, foster placement, and adoption; 3) Teach the parents about more effective "parenting skills" and how they might be applied in the home; and 4) Explore ways to enhance Brian's social skills. Encourage and support appropriate interaction with neighbors, school mates, and church members. Find other ways to foster cooperation, self respect, and self esteem.

Long term treatment goals hoped to accomplish the following objectives:
1) Through my relationship with Brian, provide a corrective emotional experience that permits him to work through issues of rejection and abandonment. Help Brian to integrate empathy, self control, and social skills into all areas of his life;
2) Uncover and work through molestation issues, especially feelings of powerlessness and shame. Help Brian identify and develop interests that would enhance his sense of competence; 3) Develop consistent and appropriate parenting practices in the family. Encourage Brian's father to share parenting responsibilities and take a more active role in Brian's emotional
development.

Initial treatment plans were implemented as I began treatment with Brian. I considered Brian's molestation of Alisha and his own possible molestation to be central to his current problems, and I felt that these issues needed to take priority in treatment. It was important to help Brian find a way to stop the molestation of his sister because I was worried about her and because Brian might be removed from this home too, as he had been removed from numerous foster homes in the past. Psychologically, this would have re-enacted Brian's experience of being abandoned and fueled his sense of powerlessness, to which he may have reacted by increased acting out in an attempt to defend against his feelings of powerlessness. In addition, the probability of being adopted permanently again would be slim and Brian would probably be further exposed to victimization. Finally, if he were removed from this home, he would lose the only stable relationship of his life, that which he had with his sister Alisha. I hoped to help make the molestation stop so that Brian would not lose the best chance he had been given in life thus far. I was also concerned about Alisha and the way in which she was being victimized. It was clear that this had to be addressed immediately.

Since Brian was a child perpetrator and was receiving treatment while still a child, I felt optimistic about his potential for a successful outcome. I felt great compassion for this young child who had endured so much pain that he would, in turn, inflict pain upon others.
In the beginning of treatment, Brian was reticent about playing with the toys in the playroom. I felt that this reticence was in part a manifestation of Brian's hesitance to engage with me (after all, this might represent another relationship he would soon lose). It may also have represented one way in which Brian could exert control over yet another situation where his wishes had not been ascertained and he was being forced to comply. Our first sessions, therefore, were spent talking to each other as I tried to convey my interest in him. I wanted to get a sense about who he was and what his world was like, so I asked him many questions which he answered in a sullen voice with intact but brief answers.

Therapist: How do you feel talking to me?
Brian: (Shrugs)
Therapist: Do you feel like you were forced to come?
Brian: (Shrugs again)
Therapist: I know that sometimes adults force children to do things they don't want to do. Sometimes they do it because they care and want to be helpful but sometimes they do it to be mean and hurtful. I think your mother brought you here because she would like it if you all got along better. I think she wants to be helpful. I know I want to be helpful. (Client begins to look at therapist, suggesting that some of this is being heard). I can't help your family without your help Brian. Perhaps you and I can have fun together here and also find
ways to have fun with your family without any body being hurt or made to feel bad. (Brian's barely perceptible nod suggested that he heard me but his reluctance to engage quickly made sense given his history).

Given my grave concern about Brian's molestation of his sister, I felt the need to address this early.

Therapist: Brian, do you know what I mean when I use the term "molest"?
Brian: Yeah, you mean when you touch and play with someone's private parts.
Therapist: Your mother tells me that you molested your sister Alisha. Did that really happen Brian?
Brian: Yes.
Therapist: How did you feel about doing that to her.
Brian: (Sits without making eye contact and does not answer).
Therapist: Were you glad about what you did to her?
Brian: No (the reply is forceful and angry)!
Therapist: Were you sad about what you did to her?
Brian: No (the reply is unemotional and stoic in nature).
Therapist: Were you sorry that you did that to her?
Brian: Yeah (the response is hesitant and he looks away from my direction as he responds).
Therapist: How many times did it happen Brian?
Brian: I don't know (tone is once again sullen and angry)!

Therapist: Do you think it will happen again?

Brian: I don't think so.

Therapist: I'm glad to hear that Brian. Brian did anything like that ever happen to you?

Brian: No!

Therapist: Brian, this is an uncomfortable topic to discuss. Are you feeling uncomfortable?

Brian: No!

Therapist: You appear angry to me. Are you angry?

Brian: No!!

Therapist: What's that strong "no" about?

Brian: I don't know!

Therapist: I think that there are a couple of possible reasons. First of all, if something like that did happen to you, you may be angry at the person who did it, you may also be angry at me for bringing it up. Does that sound right to you?

At this point, Brian softened and shrugged his shoulders. After probing a bit more with Brian again tensing up, I sensed that this was as close to a yes as I was going to get and I decided to back off. Even though we appeared to reach a dead end with regard to this topic, once Brian entered therapy, molestation of the sister would never be reported again. I believe that by
making my knowledge about the molestation of his sister explicit, coupled with interventions to provide more appropriate ways of relating to individuals (which will be discussed in more detail later), Brian was able to end the molestation. I did on several occasions tell Brian how proud I was of his decision to not molest Alisha anymore. We also discussed together ways to express feelings that did not hurt others. Although I asked Brian again if anything similar to his sister's molestation had ever happened to him, his response was a blank. He then looked away from me and he quickly said that nothing like that had ever happened to him. I had subsequently steered him toward the anatomically correct dolls, wondering if his play with them would provide hint of his own victimization. He showed me how he had touched his sister and used his finger to penetrate her, but once again denied that he had ever experienced such a violation himself. There were blocks in the therapy playroom with phallic or orifice symbols on them. These blocks will often be a source of interest for children who have endured molestation, but Brian avoided them, and continued to deny that he himself had been a victim. When I saw Brian's resistance, I told him that I could understand that if he had been hurt himself, that it must be scary, embarrassing, and uncomfortable to talk about. I wanted to assure Brian that if something like that really did happen to him, I'd be sad and concerned for him. I also let him know that some children who are hurt in that way feel angry and hurt and sometimes try to hurt others in the same way they were hurt. I said their feelings were understandable but that they usually learned it
was better to talk about it to an adult they trust and to try and find other ways to feel good about themselves. I closed by letting him know that if it's not safe, and not a good time in our relationship to discuss something like this, he's the one to make that decision. I was aware that trust would be something that would need to develop between us before Brian might feel comfortable to disclose what must have been a humiliating, degrading, and disempowering experience, if he himself had been molested as well. This was not the thing that an already disempowered boy might divulge to another "untrustworthy" adult until very late in the therapy process. I realized that I would need to prove to Brian that I was an adult of a different sort, and I needed to find ways to let Brian know that not all relationships in life would be ones in which he would be the inferior, the powerless, and the loser.

I did let Brian know that if he had ever been molested and wanted to talk about it, I would be available and responsive but would not force him to talk about it. I was aware that forcing him to talk about it would only dynamically replay the force-compliance routine that characterizes victimization and I wanted to emphasize that in our relationship Brian had the power to choose when to discuss this issue.

Normally I do not request that the parent attend every session, but in this family's case, I thought it would be important because Brian was so unclear about expectations at home. It has been my experience in working with conduct disorder children that family interventions are often the most powerful
and I typically try to include at least one parent in the treatment process. Mrs.B would join us for 30 minutes of our hour and a half session. This time would be spent clarifying rules, expectations, and collaborating in the development of behavior modification plans. I hoped that this would clarify ways in which Brian might become successful within the home and please his parents, but I also hoped to teach the mother some parenting skills in the process. I also hoped to use this time to help both Brian and his mother develop empathy for each other—I tried to voice each one’s point of view in ways that would make it palatable to the other.

Mrs.B was very disturbed by Brian's lack of compliance with her requests in the home. I knew that if Brian could improve in this area, both he and his new mother would be much happier. It would also represent a small "success" in therapy on which we could build. I began by discussing with Mrs.B what behaviors she would like to see change. Her initial responses had an angry, demanding quality yet were rather non-specific and global, such as "I want him to be a good responsible child". In reality, Brian had no idea what being a "good, responsible child" entailed behaviorally, therefore defining the mother's behavioral expectations became our mission during the conjoint part of our sessions.

As therapy progressed, we talked about attending to cues in Brian's behavior, learning to distinguish when he was headed for misbehavior, and how to intervene early and prevent the behavior from escalating. For example,
when Brian began to tease Nathan, the mother needed to intervene and separate them, before he became aggressive. We also talked about using "time outs", in which Mrs.B (or other family members) and Brian could be apart from each other when they were angry, then return and settle the dispute after they had calmed down. I talked to Mrs.B about identifying a "time out" area which might include a chair facing a corner and give Brian a timer with five minutes set with instructions not to leave until the timer went off. If necessary, Mrs.B might need to stand behind the chair with no verbal interaction except to put her hand on Brian's shoulder if he tried to stand up. Once Brian realized her seriousness, there would eventually be less need for her to stand close during "time-outs". I thus attempted to implement behavior modification plans that would teach Mrs.B more planful ways to control Brian's behavior.

We started out by defining some behaviors that Brian could develop. When I asked Mrs.B if she could be more specific about what she would like Brian to do, her first reply was that she wanted him to listen to everything that she said. I explained that this was too broad, and it would be difficult to figure out whether Brian were really listening. We discussed how it would be easier to chose a behavior that could be witnessed and measured. Mrs.B suggested that she expected Brian to make his bed and clean his room each day, which he regularly failed to do. I explained that our new plan would work best if we started out working with just one behavior, and later we might add more. So Brian agreed that he could try making his bed everyday. I explained that for a
new behavior, it's asking too much that Brian be perfect the first week, so we agreed that he could miss making his bed one day out of the week, and still get a reward. I asked Brian what kind of a prize would be worth working for. There was a special comic book that Brian loved. He had always seen it in the convenience store but had never had any money to buy it. Mrs. B promised to buy it for him if he complied with their agreement. We drew up a contract that had a definition of the target behavior (i.e., making his bed), the expected frequency (# of times the behavior is required per week, in this case, 6 out of 7 times), and anticipated reward if the contract was fulfilled (the comic book). Brian and his Mom both signed the contract. In addition I gave them a "Star Chart" on which Brian could plot his daily achievement by placing shiny metallic stars on the days of the week in which he had performed his target behavior. An excited look came over Brian's face as we discussed his reward, as if he had already earned the treasure.

The following week, Mrs. B and Brian returned. Brian looked intimidated and depressed. I had informed both of them that the initial period of our conjoint time would be spent checking up on progress and readjusting for the next week's work. During this portion of the session, Mrs. B immediately complained that Brian had "failed", and said she "knew he could never do what he was told". When I asked how many times he had made his bed, the mother replied that he had made it six out of the seven days, but it had taken much prodding to get him to do it. Because of that, she didn't feel that he should
have the magazine. I tried to explain to Mrs.B, in a sensitive manner, that it was important that the rules not be changed after the session. If we wanted Brian to be better at home, it was important that he get what he had earned, otherwise the plan would not work. I also empathized with her feelings of frustration at having to remind him but highlighted the fact that he had indeed successfully "met" the goals set. This example represents the difficulty sometimes faced with designing behavioral interventions. I have since learned the importance of asking families what they think the problems might be that would arise with the plan we have designed and together we brainstorm the potential "loopholes". In this instance, I suggested that for the following week we could add to the contract, "making the bed before breakfast in the morning", and that she needn't remind him. He either did his chore by that time, or he did not. We talked about how all changes to the contract would need to be agreed upon by all of us. Mrs.B seemed to understand the system better and she then agreed to give him the magazine after all as acknowledgement of his meeting the contract as originally written. I believed that this became the point in therapy when Brian started to realize that I wanted things to be more fair for him in his relationship with his mother. He began to consider that I might be his advocate and not his enemy, as other adults had been in his history. Confirmation of this fact for Brian, however, was still weeks away. This incident also signaled Mrs.B's willingness to "listen to reason" and I made overt this assessment as a positive quality to both Brian and Mrs.B. This was the
beginning of helping them identify those aspects of their relationship that were positive and worth building upon.

The weeks that followed continued to be difficult. Mrs.B continued to have difficulty with consistent follow through. For example, the following week Brian didn't get his reward, even though he met the agreement stipulated in his contract, because he had acted out at school. We again stressed the importance of rewarding appropriate behavior while trying to modify inappropriate behavior. The week after that, Mrs.B judged some other arbitrary behavior, in place of the target behavior, in order to decide Brian's lack of behavioral control for the week. It became clear to me that Mrs.B had high expectations and difficulty acknowledging the "successes". In fact, it felt as though she was actively sabotaging the system and setting Brian up to fail--further fueling his sense of powerlessness which in turn led him to respond by acting out even further. She would complain about the behavior modification process, and groan about why we would be focusing on this little stuff, "when he's such a big problem". I assured her that I understood how overwhelmed she must feel, and tried to help her understand why the inconsistency and seemingly arbitrary changes in our contracts would only be counterproductive given Brian's history. For the first few weeks it was difficult for me to control my countertransference toward her. I felt angry at her and wondered if she was pushing my buttons to reject her just as she appeared to be rejecting Brian. I also hypothesized that her behavior may have something to do with her own
"templates" and made a note to spend some time with her discussing her own family history so that I could respond to her in a more empathetic fashion. I realized that to some extent she was set in her ways and resistant. I felt, however, that keeping a calm, patient, understanding, and non-judgmental stance with her was critical in keeping her involved with Brian's treatment. I knew that I needed to model for her an ability to remain engaged and responsive despite her criticism and expressed dissatisfaction. I believed that this stance in our relationship was essential in order to enable her to adopt a similar one in her relationship with Brian.

Thus, during the following month of therapy, I met for a short time with Mrs.B alone. During this time I wanted her to get a sense that I understood how difficult this adoption experience had been for her and her family, and indeed I believed that this had been the case. She and her husband had hoped to help the children, and in the process, their lives had been unraveled.

I also spent some time getting a sense about who Mrs.B was before all of this had happened in her life. She was the oldest child from a large family. She had been raised in the inner city when it was a less violent place. Her father had been absent from the household and her mother worked long hours in order to support the children. The money from a single income, in a family with many children, didn't stretch far enough and the family was fairly economically deprived. Since Mrs.B was the oldest child in the family, she became the designated parent when the mother was gone. It was a huge
responsibility for her as a young girl and forced her to grow up before her time. Mrs. B seemed older and more worn out than her years, and I felt badly that she, like Brian, had a tough life full of unfairness. I also felt badly that what she had hoped would be a turn of good will toward these parentless children, had turned into what she considered a huge, unanticipated burden. I thus learned to relate to Mrs. B out of empathy for her. I saw that her intentions were good, indicated by her consistency in attending therapy sessions, and her devotion in trying to help Brian in the face of her frustration. Beneath her gruff exterior she was a kind woman. It was to her kind interior, and her own sense of deprivation, that I hoped to appeal in order to help her understand the painful reality of Brian's life. I hoped that if she could understand his perspective, that she might be able to love him more, and be more forgiving of him.

In order to accomplish this, I needed to make an empathic bid to Mrs. B. I responded to the feelings behind her sabotaging attempts toward the behavior modification plans. I responded by saying, "It's sad to see how much he really wants your affirmation, and that it's so hard for you to give it right now. I know you've had so much struggle in your own life and that you didn't get the kind of nurturance he is asking for and needs". This needed to be a tactful bid, so that it wouldn't be heard as punitive, angry, or manipulative. This was a delicate situation. I wanted Mrs. B to feel a compassionate connection with me, as if I had an arm of understanding around her, while saying, "This poor little guy." I hoped to provide a "secure base" or safe empathic place for the mother during
our time together. I wanted to use the relationship of caring for her to say, "In some ways he's probably looking for someplace where he can come to, and sometimes he does it in ways that are hard for you to deal with, and I hear that. But what he's really doing underneath, is he's wanting more of you."

It was my job to help the mother see that underneath this acting out, there was a hurting little child. I could do this by acknowledging the little child inside the mother, and responding to mother's little kid. In some ways, my job was to model how one can understand that negativity and criticism mask pain and frustration. I wanted to be the cognitive interpreter for the mother of Brian's behavior on a deeper level. Brian's real message was, "I want you and I need you." I could then translate to the mother, "He really likes you, looks up to you, you're so important." This was a way of being affirming to the mother, in a situation that on the surface seemed anything but affirming. It was also important that when Brian had done well, that I acknowledge his mother's contribution in that success. By doing this, I could model how to show affirmation or approval of the child in his legitimate success.

In about the fourth session, the adoptive father presented to therapy with Brian and his adoptive mother. Mr. B was a police officer, and had taken some time off of work because of a job-related injury. He came to the therapy session dressed informally in a sweat shirt and casual pants. He was a huge man, about 6'5", heavily built, and a little overweight.

When Mr. B came to therapy, I hoped to promote the idea that he and
Mrs. B could function as a team. I found that Mr. B was actually capable of being more emotionally available than Mrs. B at this time, and I had encouraged her to invite Mr. B's participation in working with Brian at home. Mr. B, I learned, had grown up in the suburbs in a family that was working class. There were fewer children in his family of origin compared to Mrs. B's, so consequently they were more financially stable. Mr. B's father had also been absent, and without a "father" role model, Mr. B had never learned how to be part of an active husband and wife parenting team from his own family. He consequently spent lots of time at work, and seemed psychologically absent to the family. I had encouraged that he play a more active role in the family by assisting his wife in monitoring Brian and following through on behavior modification plans. This could also relieve Mrs. B of some of the parenting burden, which she had seemed to take on by herself, as she had parented her siblings alone in her family of origin.

Even though the father was an impressively large and physically powerful man, he was kind and gentle. Though he towered over his wife, she was definitely the one in charge. I thought of Mr. B as "the lieutenant", taking orders from his wife, "the general". It was interesting to see them interact. Every time he would respond, she would appear to invalidate or contradict his response. I came to recognize that this represented her way of interacting and was perhaps a manifestation of her need to maintain control and have her perspective validated. This made sense given her history of being given
responsibility for her siblings with little validation for how well she had managed. However, even though Mrs. B seemed to override her husband's opinion about most things, she had respect for his superior understanding of technical issues. This included his understanding of the dynamics involved in the behavior modification contracts. He really understood the purpose of the behavioral interventions and how to implement them. He was very task oriented and would translate to Mrs. B exactly what she needed to do in order for the behavior modification plans to work. Though I myself had done this in the past few weeks, with limited success, Mr. B was able to not only put what Mrs. B needed to do into words that she better understood, but he was able to keep the program in check during the week. It was very instructive for me to observe him and the way in which he was able to get his message across. This reinforced for me the importance of seeing as many members of a family as possible when working with conduct disorder children and identifying each members' strengths and trying to utilize those strengths. Mr. B came for the next six weeks while he was still off work. He was optimistic compared to her pessimistic outlook, and Brian made great gains during that period of time. He was doing well in attaining behavioral goals and received the rewards that he had earned. Everyone acknowledged his improvement except for Mrs. B, in part because Brian had been cast into the "bad boy" role but also because her own life experiences, which had included much adversity, made her "suspicious" of success and she questioned if it would last. I acknowledged her concerns but
tried to instill optimism by noting how much progress we had made despite Brian's horrendous early history.

During this same period of time, Brian and I were continuing to make our relationship stronger. During the first few weeks, Brian was sullen and noncompliant. He did not want to play which I viewed as his attempt to exert control over the situation. I tried to align with his need for control by emphasizing that he could choose what games to play with. Brian then tested me by deliberately breaking several toys. I let him know that this behavior was not acceptable but continued to be warm and engaged with him. In this process, I began to disconfirm Brian's view that people would eventually reject him and all he had to do to speed this process was act out. In setting limits I conveyed to Brian my view that he was worth the effort. This experience seemed to help strengthen our relationship.

Over time, I also realized that both Brian and I were marking time, dreading the conjoint portion of therapy with Mrs. B. At this point, I shared my insight with Brian and asked him if he felt similarly. He agreed and shared that he was really quite frightened of his new mother. I attempted to join with him by talking about how powerful and stubborn she was. I told him that I thought he had a tough role to play because it seemed so difficult to make her happy. In addition, I said that if she was always going to be unhappy and feel that he was a "bad boy" that he may often feel that he might as well misbehave so that at least he would feel he deserved her anger. This appeared to be a powerful
thing to say to him. He stared in wonder, as if he couldn't believe his ears and was afraid to speak for fear of breaking the spell. I also shared that while this was a difficult person to deal with, that deep down, I thought she really loved him and that the task that he and I had was to draw that out of her. I also reassured him that our relationship would be different. I had rules that had to be obeyed, but they were, I thought, more reasonable, more consistent, and far fewer. There would be consequences to not obeying the rules but, I would always care about him.

This exchange appeared to change the nature of our sessions. He began to play with toys in the playroom. His favorite activity was playing "war". He would go to the sand table and create elaborate scenes with the male army figures. In the first several weeks, the theme was always the same. The "little guys" would be pitted against the "big guys". It was as if Brian could not imagine that the battle could ever be fair. It would be a tremendous battle, in which Brian would provide the sounds of the explosions, the humming of the tanks, and the screams of the dying soldiers. The outcome, however, would always repeat, and the little guys would always lose. He was fixed in this pattern and I could see in his metaphor of battle that this was the theme of Brian's life. He too was a little guy, with a history of his own failed battles, and without the hope of ever having enough power to win. Throughout this early stage, my role was that of an observer who relayed what I was seeing both metaphorically and literally.
One day, remarking yet again how much I enjoy playing war, he finally invited me to play. Brian set me the task of representing the big soldiers and he took the army comprised of smaller soldiers. Over time, the battle scenes generated detailed conversations between Brian and myself about battle strategies. I introduced to him the idea that the small characters didn't always have to lose, that they could be more clever, cunning, and planful. They could also be more agile, run faster, and hide better because they were less bulky. We talked about how some really smart military men would be in a position so high that they could get what they wanted purely by negotiation skills, saving many lives. We started to look at, and talk about, all of the ways a small guy could develop himself in order to be successful in our mock battle scenes. I hoped to offer options to Brian, as he vicariously replayed over and over again, his own position of powerlessness in his life: in his past sexual abuse; history of repeated abandonments; and his current rejection from his new adoptive mother as well.

I suggested in one session that we mix up the sizes of the soldiers in our armies, with each side having big soldiers and smaller soldiers. He was bewildered by this at first, but he was willing to give it a try. Brian began to love playing with the mixed size armies and he enjoyed the creative strategies that we would plan. We would talk about how each type of soldier had his own assets, and how the little guys could really be the best because they were so smart. Our soldiers began to develop relationships with each other and when
one guy got hurt in battle, other fellow soldiers would drag him into a fox hole, call for the medic, and the men would try to care for him in the meantime and hope that he survived. We would imagine together what it might be like emotionally to be hurt in battle. I would talk about how I really wouldn't want to lose that man, not only because he was a good soldier, but also because he was a great buddy. I gradually wanted to get Brian to be able understand that all of the men were important not only as battle objects, but also as important members of the team and as friends to each other. The battle scenes became an important way, not only to build trust in our relationship, but to cognitively develop alternative strategies that might translate into Brian's real life. For example, instead of throwing feces at neighbors to get their attention, we discussed other more socially appropriate behaviors. Over time, Brian was able to generate numerous alternatives, such as inviting kids over to play with his wrestling men, asking them if he could join a game in progress, and pitching in to help a neighbor complete a chore.

Brian's original noncompliance and petty thievery had largely disappeared. However, on one occasion, Brian tried to slip his favorite army character into his pocket. We had established early in therapy the rules of the playroom. They were very simple. Brian could use any toy in the room. However, the toys couldn't be intentionally broken, used to hurt others, they had to stay in the therapy room, and they had to be put away before the end of the session. On this particular occasion, about two and a half months into our
sessions, Mrs. B had been particularly difficult. Brian, according to mom, was slipping and she asserted that what I was doing was not working. She found that she needed to be coming down harder and harder on Brian. Although I disagreed with her assessment based on my observations and the reports from Brian and Mr. B, I dealt with Mrs. B relatively passively by asking her to be patient. Following the session, Brian told me he forgot something in the playroom and we returned to it. At this time, Brian proceeded to pilfer the soldier that had always been considered to be the leader, the most clever of them all. As Brian picked up his jacket, I saw Brian put the little plastic soldier into his pocket. I told Brian that he would have to leave the soldier in the playroom because that was the rule, but I could understand why he might like to take him, so that he could continue to have fun with him at home. I also let him know I understood why this soldier was special—he was loved and admired by others, not criticized and rejected as can sometimes happen to soldiers. I wanted Brian to know that I could understand his motivations and the world from his point of view. I also wanted him to understand that it was possible to be with an adult who could impose structure consistently and benevolently, while at the same time staying attached in the relationship. It was important that Brian know that rather than being judged only by his breach of the rules, that I regarded his acts as being separate from the core of who he was, the core that I saw as lovable and valuable in an enduring way. I wanted to focus on the consequence of the behavior, rather than how his testing behavior
effected my value for him as a person. I wanted my voice to convey a "matter of fact" tone. I wanted Brian to know that my feelings for him would not change as he tested my consistency and availability with his behavior. Brian needed to know that no matter how he tested me, I could stay emotionally connected to him. I watched Brian pull the army guy out from his back pocket and put him back in his place. We finished the clean up as usual that day, and I told him that I would be looking forward to our next session together. I believed that I had successfully passed his test. I could set firm limits for Brian while, at the same time, be accepting of him as a person. This, I felt, created safety for Brian and allowed us to develop a relationship characterized by trust. Although I believe that a crucial component of this behavior involved Brian taking a representation of me, a soldier, to help him battle his mother, I knew that I needed to respond to the inappropriateness of stealing. I considered that I would perhaps have to give Brian something concrete (perhaps another soldier) as a representation and reminder that battles could be resolved in a variety of ways. I wondered if Brian felt that I had let him down in the conjoint session and now, not only was he alone once again, but he would have to deal with a larger than life mother over the next week. In retrospect, a more effective intervention at the time of the stealing incident would have been to note Brian's "abduction" of the soldier and ask him what made him take the item. This would have provided useful information as to whether Brian could yet address his needs directly, and in the event that he could not, provide me an opportunity
to discuss the possibility that he experienced the incident with his mom as an abandonment on my part.

Indeed, in the following session, Mrs.B was less amenable to suggestions, and I found myself working doubly hard. I decided to acknowledge her strength and validate her efforts as a parent and ask her how she thought we should proceed. This seemed to surprise her and she began to acknowledge that some of the things we had done had worked. She was then much more amenable to continuing the interventions and I always made a big deal of her role and how her follow through made a major difference in Brian's success.

Developing empathy for others was a major goal of therapy. Brian needed to understand that he was not the only person to be small and "picked on". He also needed to be reminded that others who went through painful experiences had feelings similar to his own. I also wanted him to increase his repertoire of appropriate responses when these feelings arose. I began doing this work not only in the way that we would talk about the experiences of the army characters and their feelings and subjective experiences with war, but I also loaned Brian books to read and take home.

The books were a series that I had collected which used fantasy characters to demonstrate how it felt to be hurt by bigger "bully" characters. The books also explored various creative alternative solutions in order to obtain more power in a situation in which you seem to be powerless. If we had read
the stories together in session the activity would have seemed below his level, since the books were designed for children a little younger than Brian, but the reading level was just right for Brian's abilities. So the books became part of his homework assignment. I prefaced the use of the books by saying, "These books may seem a little easy for you, but the message of the characters is the important part. See if you can understand the lesson that the book teaches and we'll talk about it next week." One of the books, for example, was the story of a small dinosaur who was constantly being physically hurt and humiliated by a huge mean dinosaur [from the book *Tyrone the Horrible* by Hans Wilhelm, New York: Scholastic Inc.]. They lived in the same neighborhood and the big bully dinosaur would steal the smaller dinosaur's lunch. He would tease him, punch him, embarrass him, and hurt him physically. The smaller dinosaur had a difficult time getting to sleep at night because he kept thinking about ways he might be able to avoid the bully. The small dinosaur, Boland, thought with his friends about ways in which he could react that might change the situation. He tried every option he could think of. He offered the mean dinosaur ice cream, he tried to ignore him, and he tried to fight back, but all of these options ended in disaster. Finally, the small guy walked by the bully with a sandwich, which was quickly stolen by the big dinosaur. This time, however, the little dinosaur had been clever. He had filled the sandwich with flaming hot peppers which really burned his mouth, and the bully was never to bother him again. Brian liked these stories because they were like our battle scenes in which the little
guys could find ways to prevail through their own creativity and cleverness. We continued to discuss how it felt to be in the losing position, and explored various options to become empowered. Brian and I were able to use these books and our play with the army men to explore times when Brian himself had felt powerless and how he might respond in the future when faced with disempowering experiences.

Other than the reading homework, what Brian chose to do in our weekly sessions was always the same. The only deviation from the battle scenes with the soldiers was when Brian brought in wrestling figures from his collection at home, but the theme was always the same. It would always be lifelike human figures fighting each other. There was a lack of creativity to the play. Brian was unsophisticated and undefended in the way he compulsively repeated the conflicts that had been his life experiences. The play during my time with Brian in therapy would never move from confrontational scenes, but he showed growth in his ability to articulate the conflict between the soldiers, he became more creative in his play, and the characters gradually became capable of showing emotions and capabilities beyond their potential for aggression. Brian's growth could be witnessed by his transition from the "splitting" that could be observed in the early battle scenes, in which soldiers were either large or small, good or bad, powerful or powerless, or winners versus losers. Later battles were filled with people on both sides that were more real and three dimensional in character. This transition was an indication of growth for Brian.
As an observer and participant, I verbalized my observations about how the soldiers had grown and were not all good/bad, powerful/powerless or winners/losers but sometimes won and sometimes lost, sometimes did bad things but that didn't make them bad or unlovable. Occasionally, we would bring these issues closer to "home" and talk about whether Brian had ever thought he was bad just because he had done something bad and so forth.

Based on this growth, I returned to the issue of possible molestation. Broaching the subject, I told Brian that when he felt the time was right, perhaps he could answer some questions I had about the possibility of his being forced to engage in sexual behavior against his will. I made it clear that the choice was up to Brian, and at this time he chose to not discuss this issue. However, he agreed to let me know if some time felt right in the future. Unfortunately, I left the agency before Brian was able to address this issue and in transferring him to a new therapist made note of the importance of this in later therapy. I felt that as Brian began to feel more powerful and gained greater understanding of the fact that something bad happening to him did not make him a bad person, he would be more open to addressing this painful experience.

Brian's parents gradually learned better ways to cope with his difficult behavior. They learned new skills and gained at least some understanding of what it had been like to live in Brian's world of repeated rejections and abuses. The parents learned slowly how to plan Brian's day better in order to avoid problems, for example, getting him up earlier, and having a schedule for
activities that needed to be done before and after school. This list of activities that needed to be accomplished and deadlines (times) by which they needed to be done was posted on Brian's bulletin board as well as in the kitchen. The behavior modification plans which involved extinguishing undesirable behaviors (e.g., Brian would use foul language no more than once/day to get a star which was gradually reduced to no more than 5 times/week and later to 3 times and finally to no times/week) and developing more desirable ones (e.g., making his bed by 7:45am each morning), gradually began to become more successful as Mr. B, who was more consistent in implementation of the program, increased his participation. The interest that Mr. B had in Brian meant a lot to Brian, since Mr. B seemed to be more willing to become interpersonally connected to Brian and affirming of him than had Mrs. B. I encouraged the parents to get Brian involved in some group sports and church activities in order to develop cooperation skills and more age appropriate social skills. Brian and Nathan both joined Little League, got involved in soccer and in their church's youth group. In these arenas, they began to share more positive experiences, which was enhanced by Mr. B's participation and engagement with them.

Treatment plans were revised as therapy progressed. In the initial session, the mother had stated that Brian would purposely disobey her. I had inferred this to mean that he might be passive aggressive, but as I gathered information from Brian, I began to wonder if cognitive deficits might be causing some of his confusion. Upon further inquiry, I realized that Brian had large
lapses of memory, and could not even recollect things that should have been important to him. I would ask him to keep track of the number of times his mother had to ask him to go to bed each night, and this was difficult for him to do. He often couldn't remember the homework assignments. I began to inquire further, and it turned out that he couldn't even remember what had happened in past therapy sessions. Furthermore, he couldn't remember "fun things" he had done in the recent past. This memory dysfunction is a characteristic that is very common in children with Conduct Disorder, and it is suggested by some neuropsychologists to be a major contributor to the transgressions (see Kazdin, 1987 for review), I realized that I needed to teach Brian some memory strategies that could help him improve his memory.

I began this work by helping Brian to remember through elaborate rehearsal. We would repeat the rules of the playroom many times during the session, until Brian himself was able to repeat the rules by heart. Additionally we would make lists that helped to remind Brian of important things. This included putting a list of the playroom rules on a chart that we posted on the back of the playroom door. We would also make lists together for the coming week that were designed to help Brian remember homework or other things (e.g., making his bed or taking the trash out) that he planned to do during the week. Part of our weekly session came to involve questioning Brian in order to assess what was important for him that week. I would then write down what he wanted to accomplish in that week on a piece of paper which included each
day of the week divided into morning, afternoon and evening which he would post in his room when he got home. We would talk about how important it was to check the paper at least three times each day at home (before school, after school, before bed), and I would always ask him how much he was able to do from his list during the next therapy session. I would often model the use of lists in therapy, as we would check off our clean-up list at the end of each session.

We would also think up rhymes and funny stories that were associated with things that Brian needed to remember. I told Brian to remember the saying, "They'll think I'm being bad, if I don't make my bed." While this rhyme had its utility, it was also important to emphasize that Brian was not bad, if he did not make his bed. On the contrary, because he was essentially a good boy, he was motivated to keep his parents from thinking this. Another rhyme we used was "I must check my list or something will be missed." Hence, we would repeat the words together exaggerating the rhythm and the rhyme. The rhymes appeared to be helpful in remembering his daily tasks, and we would repeat them as we discussed his homework progress for the last week. We would also chant the rhyme before he left when we discussed the goals for the week ahead. Brian seemed to like this silliness that we shared together, and it served its purpose by enhancing Brian's ability to remember his daily assignments. It also taught him a skill he could apply in the future. These strategies were also conveyed to the parents and they learned to incorporate
them into their parenting with Brian. Mr. B, a funny and creative man, seemed to enjoy making up rhymes and songs which he used with all the children. Mrs. B would often shake her head and smile as she described how her husband seemed to be "getting into" the business of reminding the kids of their chores with a little song or poem. I was very pleased that what had been a negative task for Mrs. B (reminding Brian and the others of their chores) had become an amusing family event.

As previously mentioned, some of the most difficult aspects of this case to balance involved my feelings of urgency to address the molestation and perpetration issues with Brian before a trusting therapeutic relationship had fully developed. I quickly came to like Brian. His quietness reminded me of myself as a child and I felt a deep sadness for the pain that Brian had suffered in his short and intensely difficult life. I felt deep concern that if Brian continued to molest his sister, his new family would have a reason to have him removed from the home. After his tumultuous life history, with multiple separations, this would have been probably the worst yet since it would require that he be separated from his sister--the only lasting relationship in his life. I believe I pushed too hard, trying to get him to talk about his own possible sexual abuse, and in retrospect wonder if I should have pushed less. I also believe however, that there was a beneficial effect in discussing the perpetration right from the beginning. It made it clear that I knew what had happened (removing the air of secrecy that so often shrouds molestation), we had an opportunity to discuss
the possibility of it happening again, and I was able to open the door to future discussions as our relationship strengthened with time. Since the family was fully aware of Brian’s potential, we had also discussed ways in which they could better supervise the children in order to prevent Brian from further sexual acting out. I believe that the reason Brian was never caught bothering his sister again was due to the full disclosure within the family and the therapy setting, and not because he had become more cunning in his perpetration.

The other issue that was difficult was that of managing Mrs. B. She was challenging for me, in that she evoked lots of negative countertransference. I found her to be rigid, resistant and complaining. I used my experience of her to imagine what Brian’s experience of her might be, and this helped me to develop even more empathy for the little boy. Even though she was difficult, I knew I needed to establish a working relationship with her in order to be able to keep Brian in therapy. If I alienated her, she would pull him from the treatment as she had done with their first therapist. So I too had to think of creative solutions in order to bridge this gap I felt between Mrs. B and myself. As reported earlier, I responded to the feelings behind her frustration, learned about her own history so I could understand how her experiences were impacting her behavior, and learned from Mr. B the language and style that she seemed to respond to. Over time, I sensed that I was able to successfully join with the mother and this change in our relationship led to movement on her part. I also knew that she deserved a great deal of credit for bringing Brian to
When Mr. B came to therapy, I promoted the idea that Mr. and Mrs. B function as a team. I encouraged him to play a more active role in the family by assisting his wife in monitoring Brian and following through on behavior modification plans. Further, since he was an athletic man interested in sports, I broached the idea that he help Brian and Nathan join sporting activities. When Mr. and Mrs. B began to work together on the program they saw that it began to work. This reinforced and encouraged the father's participation without alienating the mother. In turn, this allowed the mother to let go more and allowed the father to take over more. I recommended that both she and her husband might benefit by further dividing parenting tasks. I suggested that some things might be most appropriate for the mother and other things might be better for Dad to do, and each can take responsibility for different parts. For instance, Dad might be better at the emotional nurturing, but Mom might be better at fixing dinner. So part of the intervention was to find out what each parent's strengths were and what each parent could do better or best, and they were encouraged to operate in that sphere. The parents came to understand that mom could do the caretaking in terms of functional issues, (i.e. getting the kids to school) while Dad could do more caretaking on an emotional level, which included playing and talking to them more.

In the therapeutic process, relational re-enactments manifested themselves in several ways. What I expected Brian to recreate with me in the
therapy session was his role as the "kid not worthy of being loved." I thought that "acting out" would be a major problem in the treatment setting. This did indeed occur to some extent in the initial part of therapy. Compared to many children with conduct disorder, however, it was relatively minimal and all but disappeared when he learned to trust our relationship and became connected to me. I had a sense that Brian had been the loser with adults so many times that he had conceded to be powerless with them. Brian was surprised by the respect that I paid him as we would play "army" side by side. I thought that our process together was enacting a solution to his conflicts as we would talk about our strategies together as equals, rather than me being the directing adult and him being the submissive child. He couldn't believe that I would consider him capable of making good decisions and because of that, he was cautious with me. It took him some time to become less skeptical about my credibility, but as Brian began to feel more powerful, and he saw that I was consistent and sincere, he gradually began to trust me.

I also believed that Brian was quite depressed at the onset of treatment. As he gradually saw that he would not be a victim in our relationship, however, this freed him to move beyond his ritual of the little men losing to the big men. He was freed to try new plans and think about new ways of conceptualizing the battle field. These changes may have seemed small out of the context of Brian's life, but for him, these were great leaps. The rigidity in his play reflected the repetitive theme of his life, that of powerlessness and victimization; and his
attempt to defend against these was evident in his acting out, especially in his victimization of others. Within our relationship, and with his new family, there was now the possibility for more positive outcomes. In many ways this had been threatening for Brian, because there had been predictability and a security that came from knowing that he would always lose. In many ways this consistent pain and turmoil had become a primary attachment for him, since this had been the only thing he could really count on throughout his life. Like all children who have suffered such life experiences, he would feel insecure and threatened as the prospect of a better life became possible since this was foreign and unfamiliar to him. It was this expectation that all relationships with him would eventually fail that induced Brian's caution and suspicion about his new family life and in our relationship. Over time however, consistent warmth and respect lead to true trust on his part in our relationship. In time, I believe, this generalized somewhat to the relationship between Brian and his adoptive parents.

The biggest impediment to therapeutic change was Mrs. B. Even though she seemed committed to helping Brian, she continued to be stubborn in her adherence to her own rules, which changed often. She was inconsistent and often expected things to deteriorate. It was difficult for her to make clear specific requests of the children, and even harder for her to be objective about rating their behavior (especially positive behavior), and delivering fair and consistent consequences. No matter how much I tried to educate her about the
power of positive reinforcement, she seemed to cling to the aversive control she had grown up with. She scolded, nagged, and degraded Brian until he complied, and when he finally did, that too was never good enough. Even though Brian had made significant gains from therapy, Mrs. B still had a difficult time admitting his progress. Her expectations for future failure made it hard for her to accept and enjoy current successes. Mr. B, on the other hand, could see that Brian had improved in small ways, and his ability to acknowledge Brian's changes enabled Brian to feel more valued in the home and more confident in himself. I tried to maintain periodic phone contact with Mr. B, since he was unable to attend therapy regularly, in order to keep him involved in Brian's therapy work, and to keep Brian's door to "approval" open in the home. I also recommended a parenting group run through the church where Mrs. B could have feedback from other parents whose cultural values matched hers but who had been able to effectively utilize positive reinforcement. This group also provided emotional and social support for her.

Therapy had lasted 11 months with Brian and his family when I accepted another professional position and would be leaving the clinic. As I terminated therapy with Brian, I felt concerned about the impact that this premature ending might have on Brian. I feared that once again Brian would feel that he was being involuntarily forced away from a relationship that he had begun to trust. In his life of abrupt and artificial endings, I feared that the close of our relationship too would be retraumatizing. I had disclosed the termination date as
soon as I decided to take the new position. This allowed us about a month before termination to begin talking about the ending. I began to summarize with Brian where we had come from, how much progress he had made, and where he would go next. We had made major gains in his home life. There had been no more reports of molesting his sister, and the sexual acting out behavior with Nathan had totally stopped. He and Nathan still punched each other and fought, but it occurred less frequently now and they also had some positive activities in common (soccer, baseball, church youth group). Brian was more compliant with his mother, even though she still had difficulty acknowledging his improvement. The biggest gain at home, however, was the increased participation of Mr. B in helping Mrs. B to manage Brian's behavior and his increased involvement in fun activities with the children. Brian had learned to respect Mr. B. He was a "big guy" who was gentle, attentive, dependable, and consistent. This was a twist that Brian had never known. I felt assured that I myself had also proven to Brian that at least sometimes "big guys" could be respectful, sincerely caring, and fair as well.

I felt that in our short time together, Brian began to feel like a more valuable person. Many people in his world were working together to improve his life. He had learned some alternative ways of conceptualizing problems and better ways to behave; and no longer experienced himself as a powerless victim who could gain control only by victimizing others. His mother still had a lot of growing to do, but I sensed she was open to continued growth with the
right therapist. Interestingly, she asked that the next therapist also be a man of color. While I did not think Brian could only work with a therapist of color, I did refer the family to a therapist that I personally knew to be culturally sensitive and, because he was a man of color, he was also likely to keep Mrs. B involved with therapy. I also knew that this therapist would be sensitive and caring enough to be able to provide Brian with the "holding environment" that he needed in order to further build trust and continue to develop in a positive direction.

I also wanted to see Brian increase his social skills and therefore referred him to group therapy with other boys. Other ways that I thought might be helpful in this regard would be to get Brian involved in other activities that could involve the building of social skills. As previously mentioned, Mr. B and I had discussed getting both of his sons on a local Little League baseball team and a soccer team. Mr. B followed through with my suggestion, and Brian and Nathan were set to play on a team for the next baseball season and were going to soccer practices. I also had encouraged church activities that could further help Brian develop skills to help him get along better with others and build a network of nurturing relationships.

About two weeks from the actual termination date, I wanted to get Brian to directly address the end of therapy with me. I said to Brian, "I think you know what it's like to leave. You've had to leave a lot of places. Do you think it will be difficult?" Brian replied in a quiet voice, "yes". "Do you think it will be
sad?" He nodded affirmatively this time. His eyes welled with tears, but he
could not articulate his sadness. I told him that our relationship had meant a lot
to me, and that I would miss him. He could not speak, but the tears began to
stream onto his cheeks, and I saw proof of this bond that had grown between
us.

It was difficult for me to terminate with Brian because I had come to feel
a real connection to him, and to understand his pain. I was concerned that if
the family did not make the right connection in therapy, that Brian would be
stranded without the support that the family needed in order to achieve Brian's
long term therapy goals. I felt better as I became sure that the family would
indeed go to the therapist that I had recommended. I also felt good about the
improved relationships within the family. Even though there was still much work
to be done, Brian had made significant progress. I could feel sure that I had
given Brian something that would never be taken away or separated from him,
that is, the experience of being with someone who really cared about him and
the hope that his life could be different. These were the gifts that would last a
lifetime.

Discussion

The major contribution of this project has been to provide two concrete
elements of how multicultural and relational counseling approaches can be wed
in the applied clinical domain. This project makes the integration of the two
abstract theories concrete. These concrete illustrations have utmost value in

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their ability to illustrate to graduate students in clinical psychology, how the Multicultural Relational Approach is actually applied in order to meet timely training needs.

This project summarized the traditional approaches of dealing with the need for multicultural awareness in counseling. It reviewed the etic approach which sought to assess multicultural differences in the interest of discovering generalities in human behavior. This approach focused on using universal commonalities as the foundation for conceptualizing clients and planning interventions to promote emotional growth and well being. The emic approach, on the other hand, traditionally has placed interest in culture specific knowledge and how each individual fits into their own cultural system. Within this theoretical approach, many emic theorists have concentrated on ethnographic differences, and patterns of cultural differences based on ethnic and racial group status.

The case studies presented in this paper attempt to incorporate both the etic and emic approaches as the therapists conceptualized their clients. These illustrations also demonstrate how this complex understanding helps the therapist to understand the dynamics of the relationship which is formed between the client and the therapist, and how that relationship needs to be different in order to provide the client with an emotionally healing experience. It is this blending of etic and emic conceptualizations, knowing how these influences manifest in the relationship between client and therapist, and how
the therapist can respond in that relationship to support healthy emotional
growth that is the focus of the Multicultural Relational Approach.

In the case of Henry, the Hispanic boy with Separation Anxiety, many
emic, or universal principals organize the therapist's understanding of the client.
The desire for a child to bond with his mother and the mother's instinct to love
and protect her child are universal human needs. A mother's grief over the
death of an infant child is an emotional response that most human mothers,
who have shared such experiences, would have in common. A woman's desire
for a lasting romantic relationship and a source of continued caring are desires
that most human beings yearn to have. In the case study of Henry however,
the therapist was able to understand how specific cultural variables played a
significant role in distorting these universal human desires.

In the case of Henry, the therapist understood how the mother's desire to
love her child had become distorted, inhibiting her child's growth, because of
her history of failed relationships and inability to completely bond with a primary
caregiver because of early childhood separation. Additionally, the therapist
understood how real dangers in the mother's country of origin, and in the
immigrant neighborhood environment, created even further distrust in the world
in which she should introduce her son. The therapist was able to realize the
importance of marriage and the act of raising children to the Hispanic mother.
He also understood the stigma of having difficulty in finding a husband and
producing a living child for the mother of his client Henry. The counselor further
saw how Henry's relationship with his father was being undermined by the
mother and her history of unmet needs.

The relational element of the therapy required that the therapist provide
safety and understanding for the mother in the therapy relationship, something
she had not genuinely had in any relationship. Also required, was the
strengthening of the parental dyad in order to provide safety for Henry. As the
mother increased emotional support outside of her relationship with Henry, she
was able to give him the message that she would fine in the world without him.
This was the message that Henry needed to hear in order to grow and develop
at a more normative pace. All of these interventions required that the therapist
understand universal human desires, specific cultural context, and how both of
these elements blended to create the atmosphere of therapy relationship. The
final work of therapy was to devise new ways of relating to Henry and his
parents which could provide "better" relational experiences, providing safety and
empathic understanding. Given this secure base, the therapist subsequently
focused on helping the clients generalize these new relational expectations to
relationships outside of therapy.

In the case study of Brian, the etic approach would have focused on the
universal commonalities in Brian's need to be defensive after so many losses,
separations, and abuse. To test his new environment, which seemed
unbelievably stable after a history of knowing the world as predictably unstable,
would seem adaptive and protective for any species. The desire to act kindly,
as Brian's family did in adopting Brian and Alisha, also seems to be a common human desire. Additionally, universal responses were also demonstrated in the frustration that Mrs. B experienced in the face of Brian's acting out and testing, which would have been a reaction shared by most parents.

Specific cultural factors, however, colored these reactions for the family. Brian was of mixed ethnic heritage which placed him in a position of often not being accepted by either darker skinned African Americans or lighter skinned Caucasians. These cultural features exacerbated his feelings of alienation and unworthiness. The mother's experience as an African American woman in American, in a predominantly Caucasian neighborhood, influenced her suspicion of the therapist and the traditional system of therapy. The mother's own experience in her family of origin, as the oldest, most responsible child in a family increased her feelings of needing to resolve behavioral issues on her own. Both parents having grown up with the limited presence of the father figure, gave them limited knowledge about how a couple might work together in the parenting process. The cultural context of the family's religious beliefs also influenced their tenacity in finding ways to help Brian through therapy.

The therapist's job with Brian's family was again, to create an environment of understanding and empathic connection with Brian and his new adoptive family. The therapist conveyed that he understood the family's dilemma, the feelings of frustration and desire to return this child that had torn their family apart. At the same time, the therapist validated the family's wish to
comply with their ideas of morality, stemming from their religious beliefs and desires to provide support to other members of their own ethnic group. The therapist conveyed to Brian the he understood that he should be leery of adults and especially adult males, but that in their relationship together, Brian could be safe and protected. The therapist worked with the family to also extend this experience of safety to Brian's home environment. The therapist worked to understand the universal human frame in the context of specific cultural factors, in order to create a relational experience that could allow Brian and his family to establish more healthy relationships in the world inside and outside of therapy.

These case studies have articulated the integration of the multicultural and relational approaches in order to create examples of the Multicultural Relational Approach as it is applied in the real context of the therapy setting. This analysis has provided models for client conceptualization and treatment planning aimed toward the goal of providing a corrective emotional experience that is specifically designed for each client, given their unique life experiences and specific cultural context. It has been the intent of this analysis to create this concrete illustration in order to facilitate the integration of this theoretical therapy model for beginning clinical practicum students in order promote the learning of therapy approaches which have the potential to bring about lasting therapeutic change for clients in psychotherapy.
REFERENCES


