CHAPTER THIRTEEN

Children’s Stories, Children’s Solutions

Social Constructionist Therapy for Children and Their Families

Jeff Chang

Social constructionism, nonstructuralism, collaboration, and pragmatism guide my work, rather than an allegiance to any particular model of therapy. Practices from solution-oriented and narrative therapy have provided most of the methods for operationalizing these guiding ideas. Although some have highlighted the differences between these approaches (de Shazer, 1993; Madigan, 1996; White, 1993), I could not help but see the similarities and the possibilities for crossover and blending of methods (Chang & Phillips, 1993; Durrant & Kowalski, 1990; Eron & Lund, 1996; Friedman, 1994; Selekman, 1993, 1997). What emerged was a pragmatic integration based on the commonalities on which I chose to focus. The following is a description of some of what I have learned from teachers of therapy, from my young clients (aged six to eleven), and from their parents. I will discuss some important ideas that guide my work, then describe some useful learnings from child development, and finally outline specifically how I apply these ideas in my work with children and their families.

SOCIAL CONSTRUCTIONISM AND NONSTRUCTURALISM

I understand social constructionism to operate at many different levels and often think of peeling away layers of an onion to make sense of this for myself.¹

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First, I perceive the “big ideas” or “discourses” that, over time and history, have been taken for granted by most people in Western culture. These include the primacy of capitalism and corporatism; the preference for knowing through modernist, scientific thought; the way women and men relate; the way races interact with one another and some dominate others; and the nature of childhood. Then I look to not-so-big ideas that influence children and families in more local ways. These rest on the big ideas. For instance, the not-so-big idea that a child should achieve “up to his potential” in school rests on the larger idea that the capitalist ladder is kinder to those who have more education. So too, the concept that children can be classified as “ADHD” or “learning disabled” rests on the primacy of scientific thinking. These I call beliefs or worldviews (see Wright, Watson, & Bell, 1996). Earlier, White (1986) called them “restraints of redundancy.”

Social construction also occurs at a more micro level. Interactions within the family and between the family and the therapist can cocreate or erode meanings of events. Asking about exceptions or unique outcomes, externalizing the problem, or requesting that family members “pay attention to what Elizabeth does when she goes to school in spite of her fear,” can erode fixed ideas. “Reality” is viewed as constituted through the language that is used to describe it (de Shazer, 1994; Freedman & Combs, 1996), and the interactional patterns in which it is embedded (Watzlawick, 1984). I call these patterns. Earlier, White (1986) referred to them as “restraints of feedback.”

In clinical practice, I usually work from the micro to the macro, since families typically experience more respect and acknowledgment when they are talking about what matters to them directly. Working with both patterns and beliefs bears directly on the problems brought to therapy, and affects the family’s experience more directly. Being aware of the discourses provides context to help me understand what I am doing, and keep me aware of the social constructions that support the patterns and worldviews.

Structuralism refers to the idea that problematic behavior is symptomatic of a “deeper” pathology (de Shazer, 1991). While the metaphor of “surface” and “depth” to describe psychosocial problems has become a truism in our culture (de Shazer, 1994), this distinction muddles clinical problems by inviting a search for etiology. With tongue only partly in cheek, White (1984) proposed that the search for etiology be dealt this way: “After carefully and painstakingly taking a history of the problem, [the therapist] announces that s/he is sure, beyond a shadow of a doubt, that the problem is caused by at least one out of seven identifiable chance events. The therapist can also state with conviction that these could be narrowed down to three or four possibilities with a further 10–15 years research into the history of the problem” (White, 1984, p. 153). In other words, “the problem is the problem” (White, 1986).
COLLABORATION

When we realize that the kinds of conversations we have with clients constitute the way they view themselves and the therapy process, we are naturally led to a collaborative stance. Collaboration has been described as “minimizing the hierarchy” (see Chapter Fourteen of this volume), “leading from one step behind” (Berg & Anderson, 1994), or “not knowing” (Anderson & Goolishian, 1992). How does one operationalize this with children, who require adult guidance, structure, protection, and indeed hierarchy?

To state what should be obvious, I do my best to listen and to treat children’s time as valuable as mine. This means including them in the conversation, listening to what they say, and respecting their unique knowledge, which may lead to unorthodox solutions. Unfortunately, it appears that we are not as good at doing this as we aspire to be. For example, Cederborg (1997) found that many family therapists, despite their belief that it is important to have children attend family therapy, scarcely spoke with them, or worse yet, assumed that they knew the children’s needs without even speaking to them. Thus, the idea that children should be seen and not heard (or not heard from) is alive and well among therapists. Including children in the conversation means using modes of expression that children prefer, as opposed to trying to fit them into a Procrustean bed of adult talk. I describe some ideas for doing this later in this chapter. In setting the stage for therapy, I address directly with children their understanding of why we are meeting and what will happen. Six-year-old Michael attended at my office with his mother Kelly over concern about his outbursts of anger.2 Like many parents, Kelly had told Michael that I was “like a doctor,” not an image that typically engenders comfort or collaboration among children.

JEFF: Michael, what did your mom tell you about coming here today?

MICHAEL: I can’t remember.

KELLY: We talked about it, remember, like a doctor?

MICHAEL: Oh, yeah. Mom said it was like going to the doctor, but for your feelings.

JEFF: Really? Do you like going to the doctor? (Michael shakes his head)

Well, when you go to the doctor, like if you’ve ever had an operation, do you do anything when you’re getting an operation.

MICHAEL: (thinking me a bit stupid) No, you’re asleep. My mom gots [sic] her gall bladder out and she was asleep. (Kelly looks chagrined)

JEFF: Right, you cannot do much to help if you’re asleep. You just go there, the doctor cuts you open, and they pull your guts out . . . and sew you
up, and you don’t do anything, just lie there asleep, right? [Michael nods his head] OK, well what I like to be called is like a coach. Were you ever in any sports?

MICHAEL: Tee-ball and soccer. My coach for tee-ball was Mr. Sykes, Caitlin’s dad. Mom . . . [conversation about who was the coach for soccer]

JEFF: So what does a coach do?

MICHAEL: Teach us how to play the game, help us practice . . .

JEFF: Right. What about if you lost really bad, 37 to 1, and you were really sad and wanted to give up?

MICHAEL: He would say, it’s not so bad, cheer up, you can do it.

JEFF: Right. So if you have a really good coach, but the players don’t try, will you win the game?

MICHAEL: No.

JEFF: And if you have players that try really hard, but don’t get shown properly by the coach how to play the game, is that good? Will that be a good team? [Michael shakes his head] And sometimes the coach can see things you can’t see from where you are.

MICHAEL: And sometimes I can see things the coach doesn’t see!

JEFF: Right. So if we work together—I’ll be the coach and you can be the player, we should be able to help you with your Temper. Deal?

MICHAEL: Deal! [we shake hands, and I invite Kelly to shake on it, too]

The coaching frame allows me to adopt a collaborative yet appropriately adult stance, and suggests to the child that his participation in solution-building is necessary.

**PRAGMATISM**

Amundson (1996) has argued that, rather than being held captive to specific models of therapy, we would do better to cultivate “pragmatic habits of thought” (p. 476). Our models of therapy must “earn their keep . . . a theory is asked to perform, to reveal itself in relation to its utility, in the light of the clinical moment” (p. 477). This means subjecting our practices to the ultimate test—the fit with the experience of the client. In other words, “If it works, keep doing it; if it doesn’t work, do something different” (de Shazer, 1988).

**CHILD DEVELOPMENT**

While some postmodern colleagues have eschewed a normalizing discourse (e.g., Madigan, 1996; Madigan & Epston, 1995; Sanders, 1997), I have taken the
position that such ideas—Erik Erikson's (1950) psychosocial development stages and Jean Piaget's (1973, 1977) cognitive development stages—can be useful if they are subordinated to the knowledge and experience of our clients (Chang, in press-a). Also, in the rush to disavow ourselves as postmodernists from normalizing, modernist ideas, the rich social constructionist literature on child development is often overlooked (e.g., Bruner, 1987; Bryant, 1979; Butterworth, 1987; Feldman, 1987; Lloyd, 1987; Smedslund, 1979). I have found the ideas discussed in the following paragraphs helpful for understanding and collaborating with children's constructions.

**Experiencing Versus Expressing**

Memory researchers and specialists in cognitive and language development generally assert that elementary-aged children have richer experiences of events in their lives than they can typically express verbally (Fivush, Kuebli, & Clubb, 1992; Price & Goodman, 1990; Nelson, 1986). In the context of conversations with adults, children are quite sensitive to their conversational partners, and begin to anticipate their listeners' needs when they converse. They engage in metacognition, that is, they evaluate what they are saying and check that it fits with criteria about the purpose and context of conversation.

**Representation and Cognition**

Children between the ages of six and eleven have typically developed the ability to de-center, that is, to construe events from others' points of view. They can create mental representations of a series of concrete actions, usually events that they have already experienced. It is much more difficult for children of this age to create mental representations of abstractions, so it is helpful if concrete objects or visual representations are used to aid the creation of representations. Inductive reasoning—the use of specific observations to arrive at a more general theory—is mastered by children of this age. Yet until the age of twelve or thirteen, young people have a very hard time reversing this process—that is, to begin with a theory or principle and hypothesize about what ought to be observed if the theory is correct (Bryant, 1979).

**Storage and Retrieval**

It is generally agreed that, before the age of ten or eleven, children do not store memories as sequential narratives. What is stored in memory tends to be very accurate, specific, and discrete, and can be organized into therapeutically useful experiences by repeated telling (Bull, 1995; Fivush & Shukat, 1995; Poole & White, 1995; Saywitz, 1995).

**Psychosocial Tasks**

Erik Erikson (1950) suggested that school-aged children have a need to exercise mastery over the world—what he termed the struggle of "industry versus
inferiority.” While stage theories of normal development have been criticized from a postmodern or narrative perspective (e.g., Sanders, 1997), experientially, Erikson’s assertion rings true to me. Children between the ages of about six and eleven love to influence the world and they love to note their impact and mastery on it. My experience as a Cub leader, as well as a parent and therapist, has provided many examples of children taking delight in being able to have an impact upon the world with their efforts.

FIVE KEY TASKS OF THERAPY

My map for a social constructionist therapy (Chang, in press-b) includes five key tasks: developing and maintaining a cooperative relationship; understanding the clients’ competencies and worldview; negotiating or constructing the problem so it is solvable; finding, eliciting, or creating meaningful experiences of change (in session and between sessions); and amplifying, anchoring, and maintaining these experiences of change. These do not necessarily need to be performed in any specific order, and you may find yourself doubling back to catch up with yourself.

Develop and Maintain a Cooperative Relationship

Imagine being at your graduate school office. You receive a phone call telling you to meet with your committee in two hours. When you ask the reason you are to meet, it is vague. Dutifully you go. The others, all senior to you, are already there. As you enter, you are informed that your comprehensive oral examination in research methods has been moved up, and in fact, the exam is . . . now. How would you react? Would you be anxious? Angry? Would cooperation come easily to you? This might correspond to the experience of a child entering therapy, and I would be tempted to ask, “Why would anyone cooperate with such a procedure?”

Inviting Custodiership from Children. Imagine for a moment another scenario. As a preteen, who was the person you always looked forward to seeing? Maybe it was an older sibling’s boyfriend or girlfriend, an aunt or uncle, a grandparent, family friend, coach, Cub or Scout leader, or teacher. What was significant about that person? If you are anything like me, it wasn’t very complicated: the person listened to you, was more fun and interesting than your parents, and seemed to really want to spend time with you. When my son Paul is around certain people (Grandpa, Uncle Matt, and my friend Scott are just three), I may as well not exist. Paul would do anything for them. In therapy we are responsible for initiating relationships that can support the child’s desire to experiment with different behaviors. Solution-focused ideas about relationship (Berg, 1994; de Shazer,
1988; Miller, Duncan, & Hubble, 1997) suggest that we fit our recommendations for client action with their relationship to our services. In the context of a lack of familiarity, anxiety, and perhaps a feeling of “I am a bad kid,” children generally do not come with a customer-style relationship. It’s our responsibility to ensure that our invitations to relationship are really inviting. One has to be a good host to “host therapeutic conversations” (Furman & Aholā, 1992).

The easiest way to do this is to get the relationship off on the right foot. From the beginning, I work to place myself in the position of a “therapeutic uncle.” If the child is in the waiting room with a parent, I make sure that I spend time on the floor, meeting the child there before inviting the family into my office. I engage in small talk about interests, schools (and getting out of school to see me), siblings, and the like. My own personality is to be a bit boisterous, and I typically use that to my advantage by acting playfully, all this before I ever get into my office.

**Goaling with Children.** The process of solution-focused therapy, put simply, is to find out what the client wants by forming a picture of hypothetical solutions, bridging from the hypothetical to real-life exceptions, and using these to negotiate the next small step. This process has been called “goaling” (Walter & Peller, 1996), since setting goals does not just happen in the first session, but is a fluid process all through therapy. Children from six to eleven have difficulty using the hypothetical big picture to generate proximal goals, but can move from specific instances to the big picture. Therefore, when children have a hard time imagining a hypothetical solution even with the aid of visual prompts, I tend to negotiate small, proximal goals with children. If the goals are simple and clear enough, it is not necessary to have them orient themselves to the larger hypothetical solutions.

Returning to six-year-old Michael, I learned he had a three-year-old sister, Marie. Like many older siblings, he found Marie to be more than a minor irri-
tant at times. We had already had some externalizing conversations about “Tem-
per.” This conversation demonstrates forming a simple goal based on the child’s life experience:

**JEFF:** So I bet your sister bugs you at times.

**MICHAEL:** Yeah! She hangs around when I’m playing with my friends.
I don’t like that very much . . . and she comes into my room and if I’m watching TV, she stands right in the way . . . last week she poked me when I was watching TV.

**JEFF:** Wow, that’s too bad. What do you do to get her to stop?

**MICHAEL:** Well, sometimes I hit her.

**KELLY:** And that’s one of the reasons we’re here and that’s what I’m worried about.
JEFF: What about when you don’t hit her? What else do you do?
MICHAEL: I don’t know.
KELLY: Well, the other day he was really good, he just walked away.
JEFF: Really. How did you do that?
MICHAEL: I said to myself, “I better get out of here or else I will get in trouble for hitting her.”
JEFF: What else do you do?
MICHAEL: Sometimes I ask her nice.
JEFF: Really, what do you say?
MICHAEL: I say, “Marie, please leave me alone.”
JEFF: What if she doesn’t listen?
MICHAEL: [casting a glance at his mother] Well, sometimes I tell her to buzz off.
KELLY: Yes, well, “buzz off” is OK, but sometimes it goes further, if you know what I mean.
JEFF: Mm hm. I’m sure I do. Michael, remember we were talking about Temper a few minutes ago, and how Temper is spoiling things for you.
MICHAEL: I hate Temper!
JEFF: Yeah, Temper is really bad to you, eh? . . . we discuss some things that Temper encourages Michael to do . . . All that stuff is pretty bad, eh?
MICHAEL: Yeah.
JEFF: I have an idea about how to stop Temper from spoiling your life.
MICHAEL: What is it?
JEFF: Well, you know how you ask your sister to leave you alone?
MICHAEL: Yeah.
JEFF: Well, I was wondering if you could tell Temper to leave you alone, just quietly, inside your head.
MICHAEL: Yeah, but what if it doesn’t work?
JEFF: Well, what is the next step with Marie?
MICHAEL: I tell her to buzz off!
JEFF: Yeah, well, don’t say anything any meaner to Temper, no swears, OK? And inside your head, just quiet, right? OK, let’s practice. . . .
[we simulate a Temper onslaught and Michael practices telling Temper to go away and even to buzz off]

As I have surveyed colleagues, students, and workshop audiences, there seems to be a consensus that at most 30 percent of those parents presenting for
child therapy enter with a customer-type relationship, that is, wanting assistance to develop new solutions. The rest perceive that there is a problem and see it as residing in the child. Why? Adults naturally think they're right. Moreover, if they have experienced traditional therapy or school-based intervention, they may feel blamed for the child's problems. I keep this in mind as I ask for parents’ help. A respectful, “not-knowing” listening style, founded on the belief that there are many possible ways to view reality, invites parents to participate as partners in therapy. I usually tell parents that it is my general practice to see the child and the parents he or she is living with in the first session to obtain the necessary information about the situation, without implying that parents are to blame for the problem.

In the initial session, I am also listening carefully about how the referral came about. The family physician or pediatrician, school, child protection worker, or grandparent may be motivated to do something. I am curious and listen carefully for whose idea it was to come, who has something to gain or lose, who might be distressed or bothered by the child’s behavior, and who might be willing to take action toward solution development.

Understanding the Clients’ Beliefs, Worldview, and Strengths

Typically, children experience problems as part of themselves, and may almost viscerally have adopted an identity of badness. Parents, on the other hand, often have well-developed accounts or causal beliefs about the problem. At times, they are well read and have developed sophisticated clinical hypotheses—often more sophisticated than mine, since I do not find structuralist explanations helpful. I do my best to listen carefully, uncritically, and respectfully, acknowledging that many different understandings of their stories are possible. I might simply listen, in what Freedman and Combs (1996) call a “deconstructive” manner, or I might ask questions that elicit beliefs (Wright, Watson, & Bell, 1996) about the problem such as these:

- What theories do you have about the cause for this behavior?
- Do you think that Ken can control the tantrums?
- Are you confident that the medication can help Troy with his “hyperness”?
- Who first diagnosed Ken with ADHD? How did he or she arrive at this conclusion?

Miller, Duncan, and Hubble (1997) note that one of the important features of a working therapeutic alliance is agreement between clients and therapist on tasks, goals, and method. Tasks must make sense to the clients given their worldview. The parents’ worldview probably contains ideas about previously attempted solutions, so it is important to understand these as well.
The Child’s Competencies. It’s important to get to know what children are good at, and how they got that way. Special talents, interests, and skills can give the therapist clues about frames of competence that the child may already experience. For example, nine-year-old Ken had been enrolled in and enjoying tae kwon do for three years. When I heard this, I looked at him as if he was dangerous and asked him to come and stand in front of my chair.

JEFF: Tell me, Ken, if I was attacking you, and I did this [directing a half-speed punch toward his abdomen], what—Whoa! [as Ken intercepted my punch]

KEN: [looking proud] That’s what I’d do!

JEFF: Wow, how did you get so fast?

KEN: [smiling] I just did it over and over again.

JEFF: Oh, you’re not so fast, what if I did this: [directing a mock punch toward his face, which he deftly deflects] Hey! [Ken laughs] OK, what about this: [kicking my leg out toward him while still sitting in my chair; he easily blocks the kick] Hey! Tell me how you got so good.

KEN: Well, I just practiced over and over.

JEFF: What do you mean, you practice?

KEN: We just do the same thing over and over.

JEFF: Isn’t it boring? Doing the same thing over and over?

KEN: No, it’s fun.

JEFF: How can it be fun? Doing the same thing over and over again.

KEN: You get better at it the more you do it.

JEFF: Oh, and it makes you feel good to get better at it. So practicing works to help you get better. I see.

KEN: [a bit exasperated with me] Now you get it!

JEFF: But OK, tell me this: is practicing kind of hard sometimes?

KEN: Yeah.

JEFF: So don’t you feel like giving up?

KEN: Well, sometime I do, but I don’t.

JEFF: Why not?

KEN: I think about how I got better and what I’m learning.

JEFF: What about at first, when you were still new and your learning was slow?

KEN: It was harder at first.

JEFF: . . . but you kept going. You stuck with it?
KEN: (proudly) I kept going!
JEFF: Do you know what “persistent” means?
KEN: No.
JEFF: Persistent is when you stick to something and stick with it and
stick with it, and don’t give up, even if it is hard. Do you think you
are a persistent person?
KEN: (proudly) Yeah!

There are multiple views of this vignette. From an Ericksonian frame, Ken
and I symbolically practiced his being in control while we had a metaphorical
conversation about the nature of change. At a content level, we know that he
has had at least one experience in his young life about practice and repetition
leading to learning and change. From a social constructionist perspective, we
might say that this conversation, in a small way, was constitutive of Ken’s self-
concept—he didn’t previously think of himself as persistent, or competent in
other ways, until this view was drawn forth, but now perhaps persistence is an
emerging part of his emerging identity or self-concept. As it turns out, Ken was
able to see persistence as an attribute when he was overcoming Temper.

**Negotiate or Construct the Problem So It Is Solvable**

A solution-focused approach would generally look to develop hypothetical solutions (Berg, 1994; De Jong & Berg, 1997), perhaps by posing the “Miracle Question” or a variety of other possibilities (Walter & Peller, 1992).\(^3\) The client’s response to the Miracle Question is typically used to bridge to real-life exceptions: “Is any small part of this happening already?” This process is much like the process of beginning with a theory or general principle and predicting what might happen in light of the theory. Especially with children, if this is only done with verbal as opposed to visual representation, the therapist will probably face a litany of “I-don’t-knows.” I have found it useful in these cases to use more experience-near representations of hypothetical solutions, such as drawing or acting out the scene. Consider Ben (aged eight), who was troubled by outbursts of aggression largely provoked by his younger brother, who taunted him by making faces and calling him names. I took the role of his brother. Ben chose to imagine a miracle of turning himself into a “mute” (although I think he meant “mime”) and therefore not talking back to or threatening his brother when he was feeling provoked. As a “mute” he was able to experience himself as having mastery over his feelings of anger, as having fun, and being funny. Ben also practiced appropriate ways of telling his brother to stop bothering him, and controlling the welling feelings of anger that he often experienced. Ben was able to imagine and enact his parents’ reactions to his helpful solution behavior.
Children can also be assisted to develop hypothetical solutions by drawing pictures of the miracle. The visual portrayal of hypothetical solutions helps children enrich their descriptions of what the solution will look like. With nine-year-old Zachary, the interactional component of the miracle drawing was particularly influential with his parents. He was "doing my homework, listening, and not swearing." He drew his mother spending time with him in the evening like she used to "before my temper got bad." He put his father in another corner of the drawing patiently helping Zachary with homework. The drawing prompted Zachary to identify more instances in which parts of the miracle picture had already happened. Previously discouraged and self-blaming, Zachary's parents, Jim and Rita, were affirmed when Zachary was able to identify helpful aspects of their behavior that were already happening. It was not difficult for them to keep doing more of what was working. Rather than commenting on what they were doing wrong, and trying to correct them, their son commented on what they were doing right.

Although I use art material and play as media for expression, I do not consider what I do to be "play therapy" or "art therapy." I greatly respect those trained in these modalities. My goal is not to elicit material with the purpose of intervening in unconscious processes, nor to create a transference-type relationship to allow a corrective emotional experience. It is simply to allow room for alternative avenues of expression for my young clients.

**Videotalk: Developing Clear Problem Descriptions.** While a focus on solutions, exceptions, and competencies is to be preferred, at times it is necessary to seek a problem description. When the clients' (particularly the parents') experience and conversation is so dominated by the problem that interrupting them would be seen as disrespectful and dismissive (Nylund & Corsiglia, 1994), I ask them to carefully and specifically describe the problem pattern. O'Hanlon and Weiner-Davis (1989; see also Chapter Seven in this volume) call this "videotalk." In a social constructionist therapy, questions do not function merely to get information, but to give information and imply different or multiple ways of viewing things to the one questioned. So, by seeking a clear behavioral description, I try to get information that assists me to conceptualize the problem in terms of patterns, beliefs and worldview, and discourse. As long as the focus is on the problem, I find it more useful to invite conversations that imply agency, rather than those that see the problem as a fixed entity or essential quality of the person.

Problem labels often take over the way a young person thinks of himself. Ten-year-old Matthew reported to me in our initial meeting, "I have ADHD." I wanted to turn this totalizing label into a description. "ADHD," in this case, was a constraining label and closed down alternatives for him. By asking for a behavioral description, I sought to crystallize a more helpful view that would...
open possibilities for change. To find out about the specific behaviors and interactional patterns involved, I asked questions like:

- When ADHD is bothering you, what kinds of things do you do?
- What else do you (or does he) do that you don’t want to?
- What does that look like?
- When he does that, what do you do in response?
- What do you say to him?
- Then what happens?

Sequences of behavior and interaction may be experienced as automatic. Matthew’s experience was that the ADHD was overwhelming and came upon him too fast to do much about it: “I don’t know what gets into me.” Asking about the bodily and cognitive aspects of the problem can suggest points of entry for pattern interruption (O’Hanlon & Weiner-Davis, 1989; Chapter Seven, this volume). Also, it can imply agency, as aspects of the problem pattern that go previously unnoticed can be clarified. When I asked Matthew, “What part of your body does ADHD go into?” he replied, “I feel all jumpy inside . . .”; “My hands get all tingly,” and “My leg shakes when I sit in my desk at school.”

I also asked Matthew, what ADHD said to him inside his head. He told me it said, “I don’t care,” “I think that I don’t want to do what the class is doing,” “BORING!!!!” He added, “Afterwards [after feeling out of control and misbehaving], I thought stupid, stupid, stupid!” In taking apart the problem pattern, the problem can be cut down to size and the therapist can acknowledge the family’s felt experience.  

Normalizing Conversations. Normalizing conversations can further help in cutting problems down to size. Although others have rightly criticized the discourses of normality and abnormality as pathologizing of those with unique or unusual abilities or experiences (Madigan & Epston, 1995; Sanders, 1997), I have maintained elsewhere, with apologies to Bruce Cockburn, that “the trouble with normal is the way it gets used” (Chang, in press-a). Parents may have pathologized their children by coming to hold beliefs about the way children “should” develop and behave. For instance, misbehaving boys are commonly worried about by parents who are concerned that their children “show no remorse” for their actions and appear to have “no conscience.” This may lead to interactional patterns in which the more the parents attempt to encourage remorse (or guilt) by earnestly trying to convince boys of the error of their ways, the more the boys are likely to clam up and disengage, engendering even more earnest efforts to invite remorse, and so on. This interactional pattern might be derailed by some conversation about gender socialization (C. Gilligan, 1982) or
moral development (Kohlberg, 1981). Metaphorical stories can also be told to normalize parents’ experience. Rather than resorting to mystical ideas about “using your unconscious,” it is probably sufficient to tell parents about another set of parents who faced a similar situation, and how they handled it—and of course, to observe and listen carefully to their response (O’Hanlon & Weiner-Davis, 1989). This enables the family to negotiate a more solvable problem definition based on changing a specific behavior rather than engendering remorse or figuring out why the young person is behaving in a so-called abnormal fashion. Thus the use of ideas about what is “normal” or “abnormal” should be judged by pragmatic effect (Amundson, 1996), not a predetermined position about what is appropriate. The critique of the terms normal and abnormal provides a useful caution, but should not operate as a prohibition.

Externalizing the Problem. My exchanges with Michael, Ken, and Matthew (quoted earlier in this chapter) all had elements of externalizing conversations. In such conversations, the person is addressed as separate from the problem, and therefore as having a relationship with the problem (Roth & Epston, 1996). This is not a technique but an attitude; it is founded on the belief that persons are not problems and that problems do not reside in the essential nature of persons (Zimmerman & Dickerson, 1996). Externalizing the problem decreases conflict over who is “to blame” for problems, reduces the sense of failure in families, unites family members against the problem, and opens family members to view the problem situation in different ways (White, 1988a, 1988b). This can provide the family with a mutually acceptable problem definition.

Deconstructive Questioning. Deconstructive questioning occurs as an outgrowth of deconstructive listening. This process “invites people to see their stories from different perspectives, to notice how they are constructed (or that they constructed), note their limits, and discover that there are other possible narratives” (Freedman & Combs, 1996, p. 57, emphasis in original). Curiosity and a “not-knowing” attitude inform a deconstructive stance, and deconstruction should not be confused with “reframing” beliefs or labeling them as “irrational.” The following types of questions, used in the context of externalizing conversations, might be asked of parents:

- How did you come by the idea that Jason can’t control his bed-wetting?
- How do you think your experience of childhood fears affects the way you treat Alyssa when she is fearful?
- What’s the history of the idea that boys should not give in to fears?
- Does Temper have any helpers or partners? What seems to be giving Temper a boost?
• When you think you are failing Brian as a parent, how does this affect your response to him?
• What does Hyperness do to get between the two of you as parents?

Find, Elicit, or Create Meaningful Experiences of Difference: In Session

A social constructionist therapy seeks to constitute a reality more focused on solutions, competence, and abilities than on problems and pathology. Thus, the fourth critical task in such a therapy is to inculcate, in the experience of the child and family, “a difference that makes a difference” (Nunnally, de Shazer, Lipchik, & Berg, 1986; de Shazer, 1991). This is done both in the session through the interviewing process (Lipchik & de Shazer, 1986), and between sessions by asking the child and family to perform end-of-session tasks.

Eliciting Exceptions and Unique Outcomes. I am most curious about when the problem is not present or what the family is doing the decrease the presence of the problem in their lives. Many sources provide guidance as to how to ask such questions, which, from a narrative framework, can be seen to elicit “unique outcomes” or “sparkling moments” (Freedman & Combs, 1996; White, 1988b), and from a solution-focused framework can be seen to elicit “exceptions” (De Jong & Berg, 1997; de Shazer, 1985, 1988; Walter & Peller, 1992). Since children recall and experience their lives more richly than they can say, nonverbal modes of expression are useful in generating the news of a difference.

Drawings of real-life exceptions and solutions reify the experience of mastery and enrich the verbal descriptions that children and their parents provide. Kayla (age eight) drew a picture of her being able to go to school without fear. The picture prompted her to recall that she has been reminding herself that she had specific friends at school, that she has reviewed with her mother that morning what to do if she had gotten “queasy” at school, and that when she did notice herself get “queasy” with “butterflies in my stomach,” she took a deep breath. Kayla took copies of the drawing to school and her bedroom to serve as a reminder of what to do. For children at this age, a visual representation is useful to prompt recall of helpful associations, and to enrich and deepen the experience of mastery over the problem.

The Highlight Package. Since routine is important to children, I generally conduct sessions in fairly predictable ways. Boys especially, who make up most of my preteen caseload, usually know what the highlights are in a television sportscast. In Canada, where I practice, many boys are particularly cognizant of hockey and whether their favorite player scored or made a great save. Thus the highlight package has became a fixture in my sessions. The second and
subsequent sessions typically begin with a revisitation of “great plays,” “goals,” and “fantastic saves” that the young person has made. The family is asked to prepare for the highlight package by selecting out the “plays of the week” to report to me in the next session. Thus, this interview procedure links to a between-session observation task as well. One enthusiastic father, a hockey fanatic, helped his son develop a play-by-play report of the highlights in the distinctive cadence and phraseology of the late great Canadian hockey announcer, Danny Gallivan. The highlight package forms a ritual to begin each session by discussing the solution behaviors since the last session. Family members often correct each other (children love to correct their parents with my playful support) to ensure that the highlight package is the first order of business.

**Interactive Storytelling and Writing.** The framework of a short story (see Durrant, 1990)—with a beginning, middle, and end stage, and with the child client as the central character—engages children and provides a familiar linguistic structure. I usually take the role of scribe and editor, although parents are often interested (or drafted by their children) into doing this. Typically, we use ten or fifteen minutes at the end of the session to commit the story to paper or computer. The beginning of the story is informed by the problem description. The middle part of the story is developed over several sessions, and is edited to focus on the highlights and solution patterns. The ending of the story points to a problem-free future in which the goals of therapy have been met. The narrative structure provides more coherence for children, since it is more likely that they will have the cognitive ability to project forward in time from a symbolically represented event, as opposed to projecting backward from a hypothetical solution. It should be noted, again, that the stories are not interpreted by the therapist. Here, the stories simply provide an alternative means of expression for children who are less fluent in typical therapy-type conversation styles, in contrast to other models (e.g., Gardner, 1971), which use the stories as material for intervening in unconscious process.

**Scaling.** Scaling questions (De Jong & Berg, 1997) are used in solution-focused therapy to track progress as experienced by the client and to negotiate incremental goals. With children, visual representations can be used to assist the child to communicate experience of the problem and to differentiate “what it will be like when it goes up a notch.” Janet Roth and Christina Hayes of Australia have developed a scaling kit that contains a number of “interesting concrete items (usually, but not always, ten of each), which help to ‘make the intangible become tangible.’ Roth’s favorite is a “face (royal blue and about ten inches across), with a big soft red fluffy nose, two large beaded eyes, and ten glass teardrops that are held in a small red satin drawstring bag.” The chil-
dren put the teardrops on the face to scale sadness (J. Roth, personal communication, 1997).

**Enactment and Rehearsal.** Solution behaviors can be playfully acted out instead of simply discussed. When clients are willing and interested, doing this can lead to rich experiences of difference. Recently, ten-year-old Jesse and his mother, Lorraine, demonstrated for me in session a number of solution patterns such as how Lorraine helped Jesse to calm down after an argument; how Jesse got ready for school and made his lunch without prompting in the morning; and how Jesse made a decision to come home right away after school instead of taking off with his friends, among others.

**Find, Elicit, or Create Meaningful Experiences of Difference: Between Sessions**

End-of-session interventions are used to increase the clients’ noticing of solution patterns and increase the performance of solutions, “changing the viewing and doing of the problem” (O’Hanlon & Weiner-Davis, 1989). While relationship styles of “visitor,” “complainant,” and “customer,”9 the presence or absence of exceptions, and whether the exceptions are random or deliberate (De Jong & Berg, 1997), are all typically used by solution-focused therapists, I tend to depend on the relationship pattern almost exclusively when working with children. This is because, with children, I find it more helpful to develop the experience of competence and mastery—“industry versus inferiority” (Erikson, 1950), as it were—rather than be concerned about whether the reported exception is a real-life one, or whether it is random or deliberate. Because children find it difficult to express all they’re experiencing, I focus on enriching and deepening their experience. Also, as solution-focused therapists tell us (Berg, 1994; Berg & Miller, 1992; De Jong & Berg, 1997), relationship patterns are highly fluid and can depend a great deal on how the goal is negotiated. Therefore, I tend to develop simple and focused tasks for children. The frames of *practice* and *experiments* are particularly useful. For example, with Michael, I negotiated a simple task, namely, “telling Temper to go away, inside your head, and if Temper really starts to fight back to tell him to buzz off.”

On the other hand, with parents, I remind myself to be more conscious of their experience of exceptions—do exceptions seem random or intentional? As I noted earlier, it is my observation—confirmed by colleagues, students, and trainees in my workshops—that about 30 percent of the time, parents enter the first session of therapy concerning their children in a customer-style relationship. Most often, they are looking to the therapist to work some magic with the child. They have a felt experience of the child’s problematic behavior, but may not feel that action on their part is involved in the solution. Therefore, in the first session, I usually ask parents to be on the lookout for small behavioral
changes made by the child. In the next session, 1 attribute “positive blame” (De Jong & Berg, 1997) to them for the changes. I follow a fairly standard solution-focused manner of developing an end-of-session intervention, with compliments, a bridging statement, and a homework task (De Jong & Berg, 1997). For example, I gave the following message to Michael and Kelly:

I want to say a few things because I was so impressed with what I saw today. First of all, Kelly, I want to note how perceptive you are. You have given me a lot of information today about Michael’s behavior, which is very valuable to me in thinking about what is going on. You’re very good at noticing what he does. Also, your concern is very well placed and not overblown at all. I think that the timing of your contacting the EAP [Employee Assistance Program, the source of the referral] to come here was great, since we can nip this thing in the bud. Michael, you have some good ideas already about how to keep Temper from spoiling your life. And you did a great job practicing some new tricks to get Temper away. Michael, I would like to ask you to keep practicing the tricks we practiced today for how to keep Temper away. Kelly, because you are so good at observing, I would like to ask you to keep track of any small changes that occur in Michael’s behavior, so that you can let me know what he did and how he did it, and also notice the changes that occur in your responses to him.

Retelling and Rereading. Child development and memory specialists tell us that when children retell accounts of their lives, it prompts recall. I would assert that retelling stories of competence enhances their robust experiences of competence. Seven-year-old Bradley and I wrote a story in which he was featured overcoming the “Squirmies” (his name for attentional problems). Reading this story aloud with one of his parents (sometimes he would read and sometimes his parent would read) was a regular habit (two to four times a week) for about six weeks. New developments in the story were added as the therapy progressed.

Ken, the tai kwon do aficionado, had regular “bragging meetings” with his mother most evenings. She was given a little instruction about how to ask about exceptions and unique outcomes, and Ken was asked to keep track of what he was doing to overcome Temper at school.

Amplify, Anchor, and Maintain New Experiences
In subsequent sessions, the emphasis is on amplifying change. Ideas about questioning to amplify change, from either a solution-focused or narrative perspective, can be found elsewhere (e.g., De Jong & Berg, 1997; Freedman & Combs, 1996; Walter & Peller, 1992; White, 1988b). I might be inclined to modify these guidelines by emphasizing “how” questions with adults (whose ability to recall and recount events may provide more useful information in this regard).
whereas with children, I tend to de-emphasize "how" questions and instead focus on the retelling of the problem-free situation or problem-defeating behaviors so as to inculcate these into the child's experience. The child's experience of competence is enhanced in the retelling.

Creating an Audience for Change. Many other practitioners have written about therapeutic letters, certificates, celebrations, and rituals in a more thorough manner than I could do justice to here. Letters that summarize and highlight competencies and strengths (Nylund & Thomas, 1994; White & Epston, 1990) serve to enrich and thicken the descriptions of solution knowledges. Clients have reported that letters are worth between 3.2 and 4.5 sessions of therapy (Freedman and Combs, 1996). Certificates (Freedman & Combs, 1996; Metcalf, 1995) are also useful in this regard. Nylund (1997) has used a "news release" format that is faxed or sent to relevant people in the child's social context. Recently, I've been experimenting with using a cyber consulting group in which colleagues in all parts of the world, and their clients, have corresponded with my clients and exchanged solution knowledges by e-mail. Children are particularly excited by getting a response from an age-mate in Sweden, New Zealand, or California, exchanging advice about how to deal with a vexing problem. Making knowledge public—with the client's consent, of course—by opening up meetings to teachers, residential staff, or social workers, circulating letters and certificates to others, and having celebratory meetings to highlight change—can give children a useful sense of mastery, share their success with others, and sensitize others to attend to solution behavior instead of problem patterns.

THE HEART OF THE MATTER

In this chapter, I have listed guiding ideas of social constructionism, non-structuralism, pragmatism, and collaboration; relayed useful knowledge from developmental psychology; and described how I have operationalized these ideas in clinical practice. But nothing I've said so far touches the heart and soul of working with children. Stephen Gilligan (1996, 1997), discussing his Self-Relations Model of psychotherapy, assumes that we have "an indestructible tender soft spot" that "exists at the core of each person." As an example of connecting with the tender soft spot, he writes, "everyone has had the experience of being 'turned on' by the presence of a young life" (1997, p. 4). I noticed this as I began to listen seriously to children, not simply to see them as a hassle in conducting and managing sessions. Please open yourself to the felt sense of your tender soft spot and the connection to that of your clients, young and old.
Endnotes

1. I realize that by using the term level I am using a structuralist metaphor.

2. Names of all clients have been changed so as to protect their confidentiality. All clients, young and old, consented to the use of their stories in this way.

3. The Miracle Question: “Tonight, while you were asleep, suppose a miracle happened, but you were not aware of it because you were asleep. What would be different the very next day that would tell you that a miracle had happened? What would be the first thing that you’d notice?” (de Shazer, 1985, 1988).

4. For further discussions of narrative approaches to ADHD, see Nylund & Corsiglia (1996) and Law (1997).

5. Bruce is a Canadian musician and social justice activist. I’ve appropriated the title to his song, “The Trouble with Normal” (Cockburn, 1983).

6. As de Shazer (1991, p. 50) notes, deconstruction is not the opposite of construction, whose opposite is destruction.

7. In fact, I was concerned about discussing the process of deconstruction in the section titled “Negotiate or Construct the Problem So It Is Solvable,” as it might suggest more of an interventive stance that I would intend. In any event, I decided to place it here, because unpacking or unraveling the strands of influence that undergird the problem very often leads to a subtle shift of the problem definition or the perceived locus of the problem. In the course of developing their description, people tend to turn away from an explanation based on blame, from immovable labeling and the belief that the problem “lives inside” the child, toward a view that is more open to multiple ideas or new possibilities.

8. The interesting question of how “exceptions” and “unique outcomes” may differ is beyond the scope of this discussion (see Chang & Phillips, 1993; de Shazer, 1993; White, 1993; White & de Shazer, 1996). Clients prefer both.

9. It is important to note that these are descriptions of relationship patterns, not classifications of persons.

10. The idea of “telling Temper to go away” came from the client. This is different from a cognitive-behavioral restructuring approach, especially one aligned with the so-called rationalist school, which presumes that clients’ ideas need to be changed and thus the therapist, from an expert position, identifies alleged distortions in the clients’ thinking and then prescribes the needed “correct” view (see Chapter Four of this volume; Meichenbaum, cited in Hoyt, 1996; Hoyt & Berg, 1998). In contrast, my work is more client-driven; the effort is directed toward identifying client strengths and solutions, and helping the client identify those.

11. The end-of-session intervention message is based on the therapist carefully listening for the client’s worldview, motivations, intentions, and competencies. Much of context of this particular message is not fully conveyed here because of the excerpted nature of the vignette. I would not want to give the impression that change in therapy is created largely or solely by brilliant and amazing end-of-
session intervention messages, as has been the impression generated by earlier incarnations of "brief therapy" (e.g., Haley, 1976; Madanes, 1984).

12. For a discussion of the importance of taking the client seriously, see de Shazer and Weakland, in Hoyt, 1994.

References


White, M., & de Shazer, S. (1996, October). *Narrative solutions/solution narratives*. Conference sponsored by Brief Family Therapy Center, Milwaukee, WI.
