Counseling Children and Adolescents
Connecting Theory, Development, and Diversity

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Chapter 9

Constructivist Approaches

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What we talk about and how we talk about it makes a difference.
—Berg & de Shazer, 1993, p. 7

INTRODUCTION

How profound to think that we are living what we communicate with others. Basically, how we perceive our own experiences is built around our communication within our relationships, community, and culture. Although it may seem like an abstract concept, meaning-making through language is a foundation of human development.

Because this process is developmental, understanding a child’s process of meaning-making in counseling can be challenging. This chapter offers information on how constructivist counseling approaches evolved from the postmodern intellectual movement that acknowledges the importance of recognizing the subjective realities of clients.

After reading this chapter, you will be able to

- review the history of how constructivist approaches evolved to become recognized, effective counseling approaches today;
• describe the tenets of solutions-focused brief therapy, narrative therapy, and relational-cultural therapy;
• articulate specific interventions and applications of constructivist counseling approaches with children; and
• review outcome research related to the effectiveness of these approaches.

In order to understand constructivist approaches to counseling children, understanding the historical foundations of constructivism is warranted. Compared to many of the theories and approaches used in counseling children, the underlying philosophy behind constructivism represents a different kind of thinking. Born from postmodernism, constructivism represents a paradigm of counseling that includes clients’ social and subjective realities, as opposed to the observed realities that are a foundation of modernist theories (Cottone, 2012).

The postmodern intellectual movement pertaining to science, history, and culture began in the late 20th century (Lyotard, 1992). The premise of the postmodern movement is that “what is known derives from social interaction within cultural contexts” (Cottone, 2012, p. 89). In essence, there are multiple ways to understand and “know” reality. There is no one way of knowing reality, and understanding reality around us should consider the social context of the reality we are learning to “know.”

Postmodernism is a sharp contrast to the existing modernist theories that are built on assumptions that there is an objective reality that can be observed and tested systematically through scientific method (Corey, 2013). In 1966, Berger and Luckmann wrote about scientists’ subjective experiences of the world in The Social Construction of Reality: A Treatise in the Sociology of Knowledge. George Kelly, creator of personal construct therapy, is one of the first theorists to apply social constructionist ideas to counseling. His theory purported that each person develops his or her own reality based on experiences and expectations (Kelly, 1955, 1963). Later, U.S. psychologist Gergen expanded upon Kelly’s ideas to study the social nature of human meaning making (Gergen, 1992, 2001). As ideas about how “truth” is found within social contexts and how this shapes individuals’ perceptions of reality grew, the term social constructionism evolved (Gergen, 1985). Therefore, social constructionism offered an explanation of the development of phenomena relative to social contexts. In comparison, traditional cognitive-behavioral therapies rely significantly on the behaviors and internal thoughts of the individual without much consideration of the reciprocal influence of social context on those behaviors and thoughts (Klodner, 2011).

Maturana’s (1978) work on human perception added another layer to understanding social constructionism. He found that there are limits to what humans can perceive biologically (i.e., sight, hearing, touch, smell, taste), which is defined
by the individual’s nervous system. Therefore, the “experience” of something is not dependent on the object perceived but is dependent on the relationship of the individual to what is being observed and perceived. For example, an adult enters a home and smells baking cookies and feels happy. She knows through smell that cookies are baking, but the happy feelings associated with coming home from school as a child to baking cookies meant that her family earned extra income to purchase the needed ingredients for cookies. If cookies are baking, then her family is less stressed economically, and her parents are happier and less stressed overall. Thinking or “experiencing” is a result of the nervous system being influenced by perceptual and social influences. How an individual makes meaning from these experiences is referred to typically as the psychological concept of social constructivism.

For counselors, the social constructivism paradigm grew out of postmodern ideas as a vehicle for understanding what “knowing” or “truths” clients bring to counseling (Cottone, 2013). It is still considered an emerging paradigm within the counseling arena because empirical evidence on the tenets and effectiveness of approaches and interventions is growing compared to the well-established modernist counseling approaches (e.g., cognitive-behavioral). However, differences between these approaches are notable. Interventions using modernist counseling approaches have focused traditionally on the problems presented by the client (e.g., irrational beliefs, inappropriate behavior), and problem solving is usually present oriented (Granvold, 1996). In counseling children using these approaches, interventions are less talk oriented and more focused on children’s behaviors without much input solicited about the context for the children’s needs for counseling. Hence, counseling and counseling interventions, using this approach, have corrective goals. Using a constructivist approach, historical, developmental, and cultural contexts of the client are considered in counseling. An exploration of the client’s personal meanings of the experience that brought them to counseling will facilitate a transformation of these meanings that will allow the client to perceive the experience differently. Hence, a constructivist approach incorporates the goal of meaning making and psychological development.

As social constructivist theory has developed over the last century, a debate has emerged among the theorists who emphasize the individual’s role in meaning-making and those who emphasize the extent that meaning resides in culture and language systems that influence an individual. Is the meaning of an experience constructed in an individual’s culture and this influences the individual, or does the individual integrate culture and language into his or her own sense of understanding to create meaning within? Can it be both as human thinking is quite complex? The theory as a whole is inclusive of different populations due to its focus on familial, ethnic, and cultural systems and the meaning inherent in those
systems. Implications for self-advocacy and counselor advocacy inherent in these approaches are applicable to clients of all ages, including children. Guided Exercise 9.1 encourages the reader to process how cultural contexts intersect with ethical dilemmas when counseling children.

**Guided Exercise 9.1**

**Ethics and Culture**

One of the main tenets of constructivist counseling approaches is built around understanding the client’s “reality,” which is based on his or her culture and social systems. However, ethical dilemmas may occur in counseling through this lens. What ethical dilemmas could occur specific to counseling children? Discuss with either a classmate or a small group how the American Counseling Association 2014 ethical codes apply to these dilemmas. Explain what social or cultural contexts could alter how the dilemma is resolved (e.g., child discipline being viewed as abuse depending on culture). Provide two alternative solutions to how these dilemmas could be resolved. Based on the child discipline example, would the counselor discuss discipline with the parents first, contact child services first, call the police first, or so on?

**THEORISTS AND TENETS OF THEORIES**

Although there have been several theorists who have influenced the development and application of constructivist counseling approaches, there are a few who have made a significant impact on the profession. According to Corey (2013), postmodern counseling approaches deconstruct established truths and evaluate their value in relationship to the individual’s life and experience. The counseling relationship is, therefore, characterized by open dialogue and a collaborative relationship.

Among the pioneers of postmodern approaches to counseling are Insoo Kim Berg and Steve de Shazer, codevelopers of solution-focused brief therapy (SFBT), which has been used widely in both individual and family counseling (Corey, 2013). They developed this approach in the early 1980s at the Brief Family Therapy Center in Milwaukee, Wisconsin. It is a future-focused, goal-oriented therapeutic approach that works on the assumption that for every problem, there is a solution (George, 2008). Change is constant and inevitable. Based on the foundation of constructivist counseling, SFBT reframes “problems and dysfunction” to “successes and adaptation” (Cottone, 2013). Therefore, counselors take a non-pathologizing stance with clients (Neukrug, 2011). The assumption is that clients want to change, have the capacity to change, and are doing their best to make that change happen (Corey, 2013).
Through SFBT techniques, the counselor helps clients construct an understanding of their experiences from a positive perspective (Corey, 2013). It is assumed that clients are experts about their lives (Neukrug, 2011). If clients do not identify any problems, then counselors do not attempt to help them change any behaviors. However, they may help clients identify something that works for them that needs to be practiced more often. These are typically resources that feed clients’ resiliency when there are issues occurring. Tapping into those resources will help clients’ effect change, which can occur in very small steps that lead to bigger change in their lives. Sometimes, there is no logical connection between a solution and a problem. If the solution works for the problem, then the client is encouraged to use it. Solutions to problems are relative to different clients, so one size does not fit all in this therapy. However, there are always exceptions to problem situations, so counselors can help clients discover those exceptions and create solutions around them.

For children, SFBT enhances resiliency through a lens of understanding the child’s culture and worldview. Due to its efficient nature, SFBT is optimal for use in school settings where small concrete changes can occur in a brief period of time (Corey, 2013). It also helps them learn how to find solutions to their own issues within group and school settings. However, focusing on the more positive aspects or exceptions to a problem runs a risk of invalidating the negative feelings the client may bring to counseling. This approach also assumes the clients will have the necessary skills and abilities to achieve their goals, which may be a challenge for children with intellectual, emotional, and physical disabilities.

Michael White and David Epston are the cofounders of the narrative therapy movement. Through his work in developing narrative therapy, White founded the Dulwich Centre for Narrative Therapy with his wife Cheryl in Adelaide, Australia (Neukrug, 2011). During the 1980s, White and David Epston, who lived in New Zealand at that time, developed a friendship based on shared beliefs and ideas about political systems. Subsequently, they wrote several books together that led to the development of narrative therapy.

Based on Bruner’s (1990) view that humans give meaning to their lives from the social constructions in their world by organizing their experiences in a narrative form in a sequence over time, narrative therapy was developed. Hence, one individual’s reality differs from another individual’s reality. “Narratives are self-constructed and also constructed and adapted during interactions with others” (Hannen & Woods, 2012). These narratives reflect an individual’s culture’s social beliefs and can shape and reflect the individual’s sense of identity. As White (1995) reflected, “We live by the stories that we have about our lives. These stories actually shape our lives” (p. 14). In essence, individuals engage in “storying” throughout their lives. These stories can change over time, and some stories will contradict themselves. The
narrative therapist’s role is to understand the many different stories an individual has and identify contradicting stories or stories that may be problem saturated and may cause problems in a person’s life (Neukrug, 2011). In addition to listening for problem-saturated or contradictory stories, the narrative therapist is also listening for the times in an individual’s life when he or she was resourceful. A significant impact of narrative therapy is how stories can change the client telling the story and can change the counselor who is part of the process of narrative therapy (Monk, 1997).

In working with children, the nondirective nature inherent in narrative therapy may be more helpful with children who are experiencing specific issues that promote defensiveness in the counseling setting. Additionally, stories can be “told” using a variety of mediums. For example, a child may be more willing to tell his or her story through play, drawing, acting, or music. It promotes a more creative counseling environment for the child and counselor. Guided Exercise 9.2 requires you to be creative in considering how to encourage children to tell their stories in a variety of ways.

Guided Exercise 9.2

Creative Storytelling

Directions: Work with a partner to complete this exercise. Each person will think of the story of how he or she decided to become a counselor. Individually and without the partner seeing, write out as much detail as possible about the story. Using creative methods, convey your story to your partner. For example, art, music, drama, lyrics, poems, or so on can be used. After each partner “tells” his or her story, discuss the following:

1. What were your initial feelings and thoughts about sharing your story?
2. What were the cultural and social contexts of your story? How did these influence your decision to become a counselor?
3. What were your thoughts about using a creative medium to convey your story?
4. How would children react to using this same medium to sharing their story?
5. What are some cautions to consider when doing a similar exercise with clients?

Relational-cultural theory (RCT) is an evolving constructivist counseling theory developed in 1978 by Jean Baker Miller, Irene Stiver, Judith Jordan, and Janet Surrey at the Stone Center at Wellesley College in Massachusetts (Jordan, 2008). In 1995, the Jean Baker Miller Training Institute was formed to further the development of the theory and clinical aspects of the work. Although the original work was focused primarily on college-age women, the work has been applied to males and children.

The basic premise of RCT is that people “grow through and toward connection” (Jordan, 2008). This is in contrast to many of the human development theories that
posit humans strive from dependence to autonomy and implies that individuals
grow stronger and healthier by being more independent, building firm boundaries,
and having power over others. RCT posits that a sense of safety and well-being
comes from developing good relationships and connections with others throughout
the lifespan. Jean Baker Miller noted that these “growth fostering” relationships
create “five good things”:

1. A sense of zest
2. Clarity about oneself, the other, and the relationship
3. A sense of personal worth
4. The capacity to be creative and productive
5. The desire for more connection. (Jordan, 2008, p. 2)

Mutual empowerment and mutual empathy are products of growth-fostering
relationships (Jordan, 2008). This encourages the individuals in the relationship
to grow and support each other. If not connected, chronic disconnections can
result in less energy, decreased sense of self-worth, less productivity, less clarity,
and withdrawal from relationships. These disconnections not only occur at the
individual level but also at the societal level where differences in sex, race, class,
color, and sexual orientation can be used to promote disconnection.

The primary focus of the RCT counselor is to promote, help build, and sustain
healthy relationships with their clients (Cannon, Hammer, Reicherzer, & Gilliam,
2012). Jordan (2009) reported that RCT therapy “is largely based on a change in
attitude and understanding rather than a set of techniques” (p. 5). Counselors use
RCT to encourage their clients to examine and revise, if necessary, their relational
patterns and relational images. In essence, clients should gain a sense of relational
awareness that will help them increase or deepen connections, which will give
them the tools and capacity to develop new relationships.

RCT is a constructivist approach that focuses on the relationship and how it is
perceived by the individuals in the relationship (Jordan, 2008). It incorporates the
influence of culture and social systems on the individual and how this can promote dis-
connection. In applications with children, helping children learn how to self-empathize
without criticism and blame not only promotes healthy development but also helps the
child learn connections can be healthy and beneficial. Attention and education regard-
ing social system dynamics and power encourages mutual empathy and empowerment.
The counselor can explore this through different techniques, such as individual, group,
large group, and creative counseling. Guided Exercise 9.3 requires you to conduct
research on evidence-based methods that have been proven to work with children.
Guided Exercise 9.3

Evidence-Based Creative Counseling

Although constructivist approaches to counseling center around the client’s sense of “truth” and “knowing,” it may be difficult for the counselor to obtain information from children who are not able to verbally communicate this well. What creative methods could be employed with children, so their experiences and stories are “heard” correctly? Conduct a review of evidence-based research on creative methods that represent constructivist approaches that work with children (e.g., SFBT, narrative, RCT). What are the similarities among these? What are the developmental considerations?

TECHNIQUES AND APPLICATION OF CONSTRUCTIVIST COUNSELING APPROACHES

Although the underlying paradigm runs a common theme among constructivist counseling approaches, the techniques can vary among them. For each approach, the techniques specific to the approach will be provided with a description of how the techniques can be applied to counseling children and adolescents. Specific examples of application are provided.

Solution-Focused Brief Therapy

As a foundation of providing SFBT, the counselor approaches all clients with respect and appreciation (Neukrug, 2011). The counselor offers the client a collaborative working relationship in order to find exceptions and solutions to the client’s issues that brought him or her to counseling. Without this collaborative working relationship, the results will be ineffective. The counselor needs to be flexible in the use of SFBT techniques as they should be tailored to the unique circumstances that the client presents in counseling (Murphy, 2008). The following are SFBT techniques that are applicable to use with children and adolescents:

1. Being tentative

   When the counselor meets with the client, there should be an attitude of the client is the expert, and there should be no assumptions on the part of counselor about the issue that the client will present. De Jong and Berg (2008) explained that this type of attitude is part of a “not-knowing posture.” The counselor can demonstrate this posture by being respectful and curious. Language also reflects this posture in how questions or inquiries are made of the client. For example, the counselor may test an exception out by saying to the client, “Let me know if I’m
wrong about this, but it seems like you and your brother have played together well in the past?” Another example of collaborating on solutions with a not-knowing and tentative stance would be for the counselor to say, “I would guess you play best with your brother after dinner? Is that correct?”

2. Questions

In SFBT, asking specific types of questions is one of the most important and potentially effective techniques. For older children (ages 10 and up) and adolescents, counselors may want to include questions regarding their goals for counseling. Questions regarding their hopes for the session, determining when things are better for them, and how they will know when things are better for them are referred to as preferred goals questions (Bertolino & O’Hanlon, 2002). The questions are future oriented and not focused on the presenting issue.

When exploring the presenting issue with the client, exception questions may elicit times in the client’s life he or she could identify with not having the issue or the issue was not as intense as he or she is experiencing it at the present time (Corey, 2013). The counselor will need to determine if exception questions are developmentally appropriate for the child client. However, school-age children should be able to respond to some form of an exception question. For example, a third-grade child may come to counseling because she cries at recess. An exception question to this child could be “Many people cry because they are sad or unhappy. Have there been times at recess when you didn’t cry? Can you tell me about those times when you didn’t cry at recess?” In order to coconstruct a solution with the child and find what resources she has, the counselor could asking a follow-up question, such as “What has to happen for you not to cry at recess?”

An additional type of question used in SFBT is the miracle question. The miracle question response helps the counselor and client construct therapy goals (de Shazer, 1988). It keeps the focus of counseling on the future and encourages clients to think about what they would most like to see changed about their situation (De Jong & Berg, 2008). For older children and adolescents, the question may be phrased as “If you went to sleep tonight and a miracle occurred so you would not feel so sad anymore, how would you know this, and what would be different?” For younger children, the question could be phrased as “If you had a magic wand and were able to use it to make you not feel so sad on the playground, how would you know that it really worked, and what would be different on the playground?”

If goals are constructed and the counselor and client are tracking progress in obtaining the goals through different interventions in and out of counseling, scaling questions provide a simple measurement of change in feelings, communication, or moods for the client to note progress (de Shazer & Berg, 1988). For example, the
counselor can ask the child client, “On a scale of 1 to 10 with 1 being feeling so sad that you are going to run out of tears from crying to 10 being feeling so happy that your face is starting to hurt from smiling, what would you say your number is today?” For younger children that may not understand the abstractness of a Likert scale, a shorter scale of feeling faces (i.e., smiling, frowning, etc.) can be drawn out on paper for children to choose. Another option for children is to ask them to draw their own scales at the onset of counseling and have them draw a picture to represent their scaled response for each section. Follow-up questions to their responses could include “How did you move from that space to the one you chose?” or “What do you need to do to make it move to the next number or space?” Scaling questions and responses are also simple ways to document the effectiveness of the counseling relationship but not necessarily the specific session. Case Illustration 9.1 is an example of creating and using scaling questions with children.

Case Illustration 9.1

Scaling Questions

As a school counselor whose caseload includes pre-k through second grade, you believe that SFBT is the most appropriate approach to use with the population and setting. The following is an example of how scaling questions can be used to help students in your caseload identify their feelings about the experiences they discuss in counseling. How do you see yourself using scaling in your work with children? What are some pitfalls of using the scale?

1. Construct a five-point Likert scale.

   Counselor: Today we will draw some faces that show your feelings. Some of the faces will show sad feelings, and some will show happy feelings. (Either you or the child draws five faces in a row, with varied expressions from happy to sad.)

2. Give simple directions to the child. Help them, as much as is needed, to know the meaning for each of the points on the scale. Often, children can make up their own scale.

   Counselor: We will use these pictures to help you tell me how you’ve been feeling today (or in your life). On this side, the picture shows someone who is very happy, and on this side, the picture shows someone who is pretty sad. The ones in between are happy but not-so-happy and sad but not-so-sad. The face in the middle is not happy or sad. Let’s talk for a minute about how you’ve been feeling in class lately. Which picture shows your feelings? Tell me about that.

3. Repeat the scaling activity as needed or to reflect change for the child.

   Counselor: We will use these pictures every time I see you so you can show me how your days have been going at school.

   Counselor: What would change to make your face go from here (point to sadder picture) to here (pointing to next picture on the scale)?
3. Amplification and complimenting

Amplification and complimenting are similar techniques with similar goals in SFBT. In order to reinforce the successes of clients, the successes of clients in attempting to achieve their goals in counseling are complimented (Neukrug, 2011). For example, a compliment for the child with the crying on the playground issue may sound like this: “I like how you decided to play with the new student in your class at recess. You really made an effort to play with someone new instead of waiting on the other children to ask you to play.” In order to reinforce the solution the client used, the counselor would encourage the client to expand her discussion of how the solution worked. For example, “It sounded like you decided to play your favorite game at recess to make you happy. How did you come up with the idea to ask the new student to play with you?” or “It sounds like you and the new student had a good time playing together at recess. Tell me how playing with him has helped you with feeling less sad during recess.”

Narrative Therapy

Initially, it may seem that narrative therapy techniques may be too abstract to use with young children. However, there are several techniques that work well with all children. With some creativity and modification, the use of some of these techniques can be very helpful to the counseling relationship.

1. Externalization of the problem

Externalizing the problem allows the client to not see himself or herself as the problem (Freedman & Combs, 1996). This can be key to working with children who are often identified as the problem, instead of examining behaviors, feelings, or language that has become problematic. When clients have been identified as the problem, it limits their ability to handle the issue effectively. In externalizing the problem, the problem is often named and referred to by that name within the counseling relationship. For example, the previous example of the child crying at recess could be either renamed “the crying at recess problem” or “the feeling unhappy on the playground problem.” In naming the problem, the counselor works with the client to help the client name it in a co-construction process. Once named, the client can begin to construct solutions to the problem without conflicting feelings and emotions related to feeling like he or she is the problem. In the crying at recess scenario, the child may have feelings of shame, guilt, or anger related to thinking about himself or herself as the problem that needs to be assessed and processed within the child’s social and cultural context.
2. Questions from a not-knowing stance

Questions are the most critical tools in narrative therapy (Neukrug, 2011). More importantly, questions should reflect the respectful curiosity of the counselor. Asking questions from a not-knowing stance demonstrates to clients that counselors do not have the answers to the questions they are asking. Counselors are relying on clients to educate and help them understand their experience (Monk, 1997). Questions help clients explain their experiences with the problem, cultural and system influences on the problem, and how clients have attempted to resolve the problem. This process deconstructs the problem-laden story and leads the counselor and client to externalizing the problem.

With older children and adolescents, talking through the story process and asking questions verbally may be appropriate. However, younger children may not have the ability to understand and use language to tell their stories. Some children may be able to draw a picture of their problem or make a sculpture of their problem to discuss in simpler language. Alternative techniques, such as play therapy and other storytelling techniques, can be used and will be described briefly as sub-areas to this section.

3. Play therapy and storytelling

One of the most unique methods to help young children communicate and express their emotions in counseling is play therapy (Russo, Vernam, & Wolbert, 2006). In play therapy, children’s “narratives and reconstructions occur within the context of cognitive development” (Landreth, as cited in Russo et al., 2006, p. 230). Depending on the characteristics of the client’s narrative, meaning-making may be reflected as occurring within specific stages of cognitive development (i.e., Piaget’s stages). Specifically, sandplay can apply to specific stages of cognitive development with sandplay exercises involving the use of objects and figures that children can manipulate to make a sand picture or to tell a story about the figures.

There are several sandplay techniques that are applicable to narrative therapy, but storytelling through sandplay can help children engage in storytelling and make connections between their stories and their lives (Gil, 1991). In mutual storytelling, the counselor and client work collaboratively where the counselor interprets the client’s story with the same characters and settings but offers healthier solutions and adaptations (Gardner, 1993). This reiterates the need for counselors to use clients’ words, characters, and symbols to demonstrate understanding of their narratives.
4. Mapping the problem

Through the use of questions or other creative counseling methods, clients can be encouraged to describe the influence of the problem on their lives and relationships (Epston & White, 1995). In essence, the counselor is attempting to gain a richer narrative of the problem. When did the client notice that this was a problem? How does it affect his or her life? How does it affect his or her relationship with parents, friends, siblings, teachers, and so on? Asking younger children to draw pictures of what they look like with and without the problem in their lives may be helpful, but counselors are encouraged to give specific direction to young children. For example, for the child with the “crying at recess problem,” the direction for drawing may be “Draw me a picture of you doing something at recess before the ‘crying at recess problem.’” Guided Exercise 9.4 includes an activity that allows children and adolescents to map out significant events in their lives on a time line, which aids in telling their stories.

Guided Exercise 9.4

**Life TimeLine**

A time line of life events is often used in narrative therapy to map significant events in clients’ lives. This can be a useful tool in working with children also. What are the considerations in using this with younger children? What direction would you provide? What materials would you provide? How would you process their time lines in counseling?

5. Search for unique outcomes and reauthoring stories

Questions can also be used to help clients acknowledge any actions, feelings, and language that contradict the dominant story (Wolter, Dilollo, & Apel, 2006). Similar to “exceptions” in SFBT, unique outcomes can be found in the past and present (Corey, 2013). However, some can be hypothesized for the future and can be developed into solution stories or new alternative narratives. Younger children may want to act out new solutions, and the counselor can role-play with them. Older children and adolescents may want to journal and write out their new narratives as they “try them on.” Sometimes, it feels safer for clients to prepare ideas and bring them to counseling before trying out a new narrative. This is relative to each client, and the flexibility offered through narrative therapy is conducive to the client in reauthoring his or her story.
Case Illustration 9.2 is an example of the application of SFBT to a 10-year-old male student who has been withdrawn in class. As you read through the case of Manuel, consider the following questions:

- How does the counselor orient Manuel to the SFBT approach?
- How does the counselor use active listening and problem identification (e.g., What feelings are associated with the problem? How would you rate those feelings on a scale of 1-10?)?
- How does the counselor help Manuel with goal setting (e.g., using miracle question, finding exceptions, or scaling improvements)?

**Case Illustration 9.2**

Manuel is a 10-year-old boy who is referred to the school counselor for being withdrawn in the classroom. Based on the teacher’s referral information and school records, Manuel transferred to the school this year from another state. He identifies as a Hispanic-American with both parents working and is considered to have a lower-to-middle socioeconomic status (SES). The demographic characteristics of his current school are majority Caucasian, middle to upper-middle SES, and English is the primary language of the students.

When Manuel arrives at the school counselor’s office, he appears to be apprehensive and tentative upon entering. The school counselor greets him and informs him that his teacher has referred him for a visit since he was quiet in the classroom. He displays some surprise in his facial expression when he hears this but simply nods his head affirmatively. Taking a “not-knowing stance” (SFBT), the counselor replies, “I wasn’t sure if this was the case, but your head nodding makes me think this is true. Is that right?” Manuel nods again. The counselor says, “Since I’m not in the classroom, can you tell me more about you being quiet?” This question is a way for the school counselor to remain respectful yet curious and to enlist Manuel in helping her understand the situation.

Manuel begins to talk about being new to the school and his fellow students. He explains that the family only arrived to the school community one week prior to the beginning of school, so Manuel does not know any of the children. The school counselor asks, “Have there been times when you were not so quiet in any classroom?” (Exception question) Manuel explains that he spoke up frequently at his former school where the majority of students were Mexican-American and with whom he attended church and other community-related events. Not knowing anyone at his new school, and with the majority of the other students being Caucasian, he reported that he was not sure of how he should make friends and was nervous in the classroom.

The school counselor asks, “On a scale of 1 to 10, with 1 being extremely calm and confident to 10 being extremely nervous and unsure, how would you rate yourself?” (Scaling question) Manuel answered with an eight. The school counselor also asked Manuel what he liked to talk about and participate in when he was involved more in his former classroom. Manuel reported that he enjoyed history and learning in teams. (Looking for solutions) The school counselor asked Manuel, “If a miracle happened when you went to sleep tonight, and you were less nervous and more confident in your classroom the next day, how would you know that a miracle had occurred?” (Miracle question) He said that he would be answering more history questions and volunteering to partner with a reading buddy in class more often.
Relational–Cultural Therapy

RCT is an inclusive constructivist approach in which techniques from other theoretical orientations can be applied when appropriate (Frey, 2013). Specific to RCT, Tucker, Smith-Adcock, and Trepal (2010) summarized five basic skills that are involved in putting RCT into practice: encourage, explore, educate, explain, and expand. These skills are explained and applied to counseling children.

1. Encourage

This skill is related to the counselor encouraging the client in order for him or her to develop self-empathy or self-acceptance (Tucker et al., 2010). Having empathy for one’s self and understanding self in relation to other people is a prerequisite to developing the ability to empathize with others. Self-empathy is the process of developing empathy for one’s own experiences without criticism and blame (Jordan, 1991). Although the ability to blame one’s self is related to development, children develop this quickly. Younger children may externalize emotions and beliefs on a regular basis, but gradually children internalize responsibility fairly quickly whether it is self- or other-imposed.

Similar to techniques found in narrative therapy, encouraging the child to tell his or her story (verbally or through other means) in a nonjudgmental stance provides the counselor with information on where and when self-blame was associated with the experience. Specific to RCT, the counselor provides his or her own reaction to the story and expresses empathy and compassion for the student that demonstrates the counselor’s authenticity in the relationship. For an 8-year-old crying at recess because nobody will play with her, the counselor could empathize by saying, “It must feel very lonely at recess with no one to play with you. I would feel sad and upset, too.” If the child blames herself for no one wanting to play with her, then the counselor could ask, “What if it was your sister or brother at recess with no one playing with them?” This would be an attempt to get the client to think about it differently and develop compassion for her experience. During this time, the counselor can also explore the client’s relationships with others who may be related to the experience (e.g., classmates, teachers, etc.) and examine
those connections and disconnections. With an authentic counseling relationship, children begin to feel safe to recognize behaviors that may be promoting disconnections in their lives.

2. Explore relational images

Relational images are mental templates of relationships that are based on past relationships (Miller & Stiver, 1997). Counselors may assume that children would have limited past relationships to form these relational images, but caution should be used in making this assumption. Children’s relationships can include family members, peers, authority figures (e.g., teachers, religious leaders, community leaders), and culture-specific figures. Counselors are encouraged to assess this before exploring the impact of relational images on the experience that is causing the client distress. For example, a genogram of family can provide more insight into how influential family members are and who and what are important to the client (Taylor, Clement, & Ledet, 2013). Younger children can be asked to draw their family doing something at home or their friends doing something at school. Counselors need to ask and assess to determine if there were once important people in the client’s life who are no longer important to the child. Why is there this disconnection? How has the client processed this? If the 8-year-old child has no one initiating play with her at recess, has the child rejected these relationships because she has been abandoned by peers or family members in the past? Is she self-protecting through disconnecting before she is hurt again in what she assumes is future abandonment? Exploring the thoughts and feelings around these relationships helps in creating solutions for the situation that the child brings to counseling.

3. Educate

Educating clients about power and power differentials is a core aspect of RCT (Jordan, 2009). For children, power differentials are inherent in many of their relationships with adults. However, issues of abuse influence children’s relational images negatively and provide an impetus for education about the role of power in relationships. Dominant culture also influences children’s views of self and self in relation to others. Diversity in race, gender, physical ability, spirituality, learning, and social class can be explored with children in individual, small group, and large group counseling. Bibliotherapy can be used with all age groups of children with follow-up activities that are developmentally appropriate. As children begin to embrace their own differences and those of others, the ability to empathize with self and others is enhanced. This leads to the development of mutual empathy and empowerment of each other. Guided Exercise 9.5 is an exploration of mutual empathy or mutuality.
Counselors need to assess the role of power in the experiences that clients bring to counseling. For example, if a client is being bullied or harassed or is bullying or harassing someone at school, there may be a need to reiterate limits of confidentiality due to emotional and physical safety issues related to these behaviors. If the counselor is working within the school setting, then there may be policies that direct the actions of the counselor.

4. Explain disconnections and conflict

One of the key tenets to RCT is the central relational paradox related to relationship disconnections (Miller & Stiver, 1997). Individuals can experience acute or chronic serious relationship disconnections. If they experience the latter, then they learn to keep their thoughts, feelings, and experiences out of their relationships to keep themselves emotionally and physically safe. In doing this, they do not allow for mutuality and authenticity within their relationships. For them, these “strategies of disconnection” are survival mechanisms, especially if they are survivors of abusive relationships (Miller & Stiver, 1997, p. 106). However, RCT is based on the construct that individuals are striving and yearning for these authentic relationships. If individuals yearn for this type of relationship but are protecting themselves with strategies of disconnection, this is referred to as a central relational paradox.

The 8-year-old in the recess example may have a central relational paradox occurring in her life. She is complaining that no one wants to play with her (and she desires for someone to play with her), but she may be using strategies of disconnection based on her past relationships. Examining her behaviors in the situations with classmates at recess and reframing these behaviors to explain how she is using them to protect herself from getting hurt again may allow for her to incorporate different behaviors with classmates. It is the role of the counselor to determine if

Guided Exercise 9.5

Mutuality

In RCT, mutuality speaks to both individuals involved in the relationship having mutual empathy for each other. This is also true of the counselor-client relationship. To have mutuality, the counselor is authentic with the client and shares reactions to the client’s story. How would you determine what reactions should be shared? How do your own social systems and culture influence your reactions? Think about some potential issues that children may share in counseling (e.g., poor grades, friendship concerns, discipline issues at home). Did you have any of these issues as a child? If so, it may be easy to self-disclose your own experiences. Mutuality is different than self-disclosure. Take another look at those issues, and identify the feelings associated with them. The feelings are associated with empathy. How can you convey those appropriately? How would a child empathize with you?
these strategies of disconnection are related to routine disconnections or chronic and severe disconnections, as in the case of abuse, with appropriate intervention.

5. Expand

Once clients experience an authentic counseling relationship, explore their relational images, receive education about power and differences, and learn about their own disconnections and conflict with a specific experience, the counselor encourages them to apply this to subsequent conflicts and experiences. Expanding their understanding of self and self-in-relation can help them develop mutual relationships that empower each person in the relationship and to cope with routine disconnections that may occur. Tucker et al. (2010) recommend that counselors teach children how to use I-messages in communicating with others, social skills, and peer mediation skills to promote healthy relationships and positive relational templates.

OUTCOME RESEARCH

Although outcome research for constructivist counseling approaches is growing, there is still limited research available. The following information highlights research studies that have demonstrated the effectiveness of SFBT, narrative therapy, and RCT. As with both modernist and postmodernist counseling approaches, there is still a need for more outcome-based research.

Much of the research on the effectiveness of solution-focused brief therapy (SFBT) with children is based on work in the schools applied to different types of behavioral and academic problems (Kim & Franklin, 2009). In a review and analysis of the most rigorous outcome studies on SFBT conducted in schools, Kim and Franklin (2009) calculated effect sizes to examine the effectiveness of the approach. Using Gingerich and Eisengart’s (2000) systematic review of SFBT components, Kim and Franklin (2009) determined that at least one of the core components of SFBT had to be used in the studies included in their analysis. These components included use of the miracle question; use of scaling questions; giving the client a set of compliments; assigning homework tasks; looking for strengths or solutions; goal-setting; and looking for exceptions to the problem. Mixed results were found. Positive outcomes indicated that SFBT helped students reduce negative feelings, improve academic outcomes, manage conduct problems, and impact behavioral problems and substance use in a positive direction. However, SFBT was found not to be successful in improving attendance rates or raising grade point averages (GPAs).

Overall, it appears that SFBT has a positive impact with children. It is an efficient counseling approach that school counselors find appealing. Additionally, it is positive and future oriented, which provides children and families a positive direction in intervention.
Narrative therapy. Although narrative therapy is a newer counseling approach, there are several outcome research studies that demonstrate its effectiveness with different populations and issues. Specific to working with children, Hannen and Woods (2012) conducted a study that examined the effectiveness of using narrative therapy with an adolescent who self-cuts. Using a case-study design, six sessions of narrative therapy were provided to a 12-year-old female who reported self-cutting behaviors. The Beck Youth Inventories, (2nd ed.), a narrative interview, and parent report were used to assess the effectiveness of the therapy. The results indicated that the client’s emotional well-being, resilience, and behavior improved over the intervention period.

In Ramey, Tarulli, Frijters, and Fisher’s (2009) outcome study, they wanted to validate narrative therapy founder Michael White’s map of the externalizing process with children. Eight children, between the ages of 6 and 15 years old, received brief counseling services where they received narrative therapy for a variety of issues. Each session was videotaped to be transcribed for sequential analysis. The results supported White’s map of scaffolding and concept formation in narrative therapy. Additionally, the results indicated that externalizing occurred in the sessions and was important in the therapy process with children.

In an outcome study with 10 children diagnosed with autism (ages 10–16 years), each child received five 1-hour sessions of narrative therapy conducted over 10 weeks (Cashin, Browne, Bradbury, & Mulder, 2013). Parents of the children completed the Strengths and Difficulties Questionnaire (SDQ) as the primary outcome measure while the Kessler-10 Scale of Psychological Distress, the Beck Hopelessness Scale, and a stress biomarker were also measured with the children. Although there were reductions on the emotional symptoms scale of the SDQ, there were no significant statistical differences. However, there were substantial reductions from baseline data to after completion of the therapy in psychological distress on the other measures.

Although there is a need for more outcome-related research to be conducted using narrative therapy, it is apparent that it is effective with children. Due to research consent issues with parents, guardians, and agencies/schools who serve children, research may be difficult to conduct with children. However, there is a need to continue to pursue this evidence.

There are limited studies on relational cultural therapy (RCT) and counseling outcomes (Frey, 2013). Since RCT was designed originally for work with adult women, two outcome studies were conducted with female adult participants. Oakley, Addison, and Piran (2004) applied a time-limited, manualized RCT model to women receiving counseling in a community setting. Qualitative and quantitative data were collected between the initial screening and 6 months posttreatment. On measures of depression, anxiety, alexithymia, self-silencing, self-esteem, and psychological well-being, participants reported significant improvement. Additional outcome results...
indicated significant treatment goals attainment, maintenance of gains at 3- and 6-month follow-ups, and strong satisfaction related to the RCT model and therapeutic relationship. In a second study that compared short-term cognitive-behavior therapy and RCT groups for women diagnosed with bulimia nervosa or binge-eating disorder, the results indicated that the groups were equally as effective as CBT but experienced higher levels of mutuality in the group (Tantillo & Sanftner, 2003).

Although several RCT model applications for counseling children on a myriad of topics (e.g., trauma, art, middle school) have been published (Cannon et al., 2012; Sassen, Spencer, & Curtin, 2005; Tucker et al., 2010; Vicario, Tucker, Smith-Adcock, & Hudgins-Mitchell, 2013), only one outcome-based study has been published to date. Lenz, Speciale, and Aguilar (2012) conducted a small series single-case study to assess the effectiveness of a nine-session RCT intervention with adolescent females incarcerated in a youth detention facility. Four participants elected to participate in a group that used manualized RCT group sessions. Results indicated that three of the four participants reported notable changes in at least one domain of relational health as measured by the relational health indices. Lenz et al. (2012) concluded that “RCT may be effective for promoting relational empowerment and engagement with others” (p. 17) with this specific population.

Due to the paucity of research in use of RCT with both adults and children, more research is needed. Based on the few studies that have been published, it appears that RCT is a viable constructivist approach for use with children. Quantitative and qualitative research studies would be appropriate to determine not only the statistical outcomes but also how young people are affected by this particular counseling approach. Qualitative research may also be more conducive to use with younger children with limited reading abilities. Guided Exercise 9.6 is a way to explore how you can create research that informs the counseling profession on the efficacy of using constructivist counseling approaches with children.

**Guided Exercise 9.6**

**Outcome Research**

The need for more outcome research on counseling techniques has been a key issue in the counseling profession in the last decade. The connection between documenting techniques that work and the effectiveness of the counseling relationship has not been made, and professional counselors may feel ill-equipped to conduct research. Think about a constructivist counseling approach or method to use with children that appeals to you. What do you want to know about the use of that approach/method (i.e., outcomes)? Are there specific ages or developmental levels of clients to consider? What issues would be best served with the approach/method? How would you want to measure the outcomes in order to inform you about the client as well as you own practice?
Although constructivist counseling approaches are the newest on the counseling scene, they offer counselors the ability to consider diversity and the influence of culture and social systems on clients from the beginning of the counseling relationship. From being humble and respectful in an intentional way, constructivist counselors honor clients as the experts in their lives. The power of language and relationships encourages clients to share their realities with counselors, which provides counselors with insight into how they can work with clients on resolving problematic situations, finding solutions, and connecting with others. These approaches acknowledge that all that is known is not what is perceived.

**COUNSELING KEYSTONES**

- Meaning can be found in verbal and nonverbal communication and language that children use.
- Communication and language are socially and culturally based.
- Constructivist counseling approaches take a nonpathologizing stance to children’s issues and view resiliency and adaptation as coping techniques.
- Constructivist counselors believe that all clients want to change, have the capacity to change, and will do their best to change.
- Clients create narratives that reflect social constructions relevant to their lives. These narratives or stories may change multiple times throughout a person’s life.
- By telling their stories, children may learn how relationships can be beneficial in coping with issues and developing strategies that prevent them from occurring in the future.

**ADDITIONAL RESOURCES**

**In Print:**


On Video


REFERENCES


Chapter 9 ◆ Constructivist Approaches 241


Section III

Chapter 10: Counseling With Very Young Children (0–4) and Their Families
Chapter 11: Counseling With Young Children (5–8) and Their Families
Chapter 12: Counseling With Older Children (9–11)
Chapter 13: Counseling With Young Adolescents (12–14)
Chapter 14: Counseling With Older Adolescents (15–19)
Chapter 15: Counseling Emerging Adults (18–21): A Time of Uncertainty and Hope