Contracting and establishing a framework within which therapy can take place are integral parts of the counselling and psychotherapy process. The therapeutic frame allows the therapist to define the therapeutic relationship; its terms and limitations. The therapeutic frame and contract are what differentiate therapy from other kinds of “helping” conversations such as might be had with a friend, a priest or other family member. A thoughtful and well-designed frame for therapy will undoubtedly have a major impact upon the success of the work which takes place within it. Once the frame and contract have been established and agreed upon, both parties can feel safe enough to begin the therapeutic work. The following chapter examines how the contract is important in establishing the frame for therapeutic work with children and young people and where particular care and attention are required due to the complexities of contracting with this group in private practice.

The contract

However the contract or framework for a therapeutic relationship is set out by the practitioner, there will generally be, in private practice at 25
At least, some elements of the contract which are negotiated. A practitioner may have already decided that they require a financial payment for their services and that the fee must be paid regardless of whether the client attends their session or not, while some practitioners may allow sessions to be cancelled with a certain amount of notice, or for the day/time to be altered. However flexible or firmly fixed a practitioner’s particular therapy contract is, and whatever the theoretical and clinical basis adhered to in setting and maintaining it, there are likely to be elements that are decided with clients on an individual basis. These may be something as relatively straightforward as negotiations regarding the exact amount of fee to be paid. Many practitioners offer a “sliding scale” of fees to accommodate the reality of different incomes and personal circumstances. Frequency of sessions is also something which may be negotiated when contracting as well as whether the therapy will be open-ended or run to a certain number of sessions before review or termination. When working with an adult client in private practice, these negotiations can take place between the client and therapist, generally without the direct involvement of any third party. An adult client can decide for themselves, in conjunction with their therapist, whether open-ended, twice a week therapy would be most helpful for their particular issue and whether this is something they have the necessary resources to commit to, or whether they would prefer or can only realistically embark upon a fixed-term weekly therapy to work on one particular troubling issue. The important point here is that the decision, in part at least, belongs to the client. They may have to consider whether they or the family have the funds to support them, and whether they are able to free up the time from other commitments to attend sessions. However, they also have a great deal of autonomy in choosing the terms of their therapy when compared to children and young people. With clients in this age group, most of these decisions will be made by their parents, or other parties.

For Anna Freud (1965), this presented the child or adolescent therapist with a fundamental difficulty: “Since the child does not enter analysis of his own free will, and makes no contract with the analyst, he does not feel bound by any analytic rules. (A. Freud, 1965, p. 34), suggesting that the act of deciding to enter therapy oneself is a vital component of the therapeutic contract and, without this element, there is a concern that the client has not really themselves entered into and/or fully subjected themselves to the process of analysis. This is an important point.
to consider and to be aware of when working therapeutically with this age group who are still, to a greater or lesser extent, dependent upon parent or carers. The dilemma for practitioners here is how to hold in mind and contain the third party in the form of parent or carer while also holding the child in mind as the client.

In practice, this means that in making the therapeutic contract with children and young people, the third party, usually a parent or carer, must be considered. Therapists working with this group in private practice cannot contract exclusively with either client or parent, unless the young person is of “Gillick” competency and able to fund their therapy via independent means. There are clearly the same distinctions between children of different ages and developmental stages as were encountered in the previous chapter on assessment, and a younger child will do less of the contractual negotiating than perhaps will a teenager of fifteen or older. The constant factor here is that the responsibility for payment for the therapy will usually fall upon someone other than the client themselves. This will have an undeniable impact on the process of contracting and carrying out therapeutic work in the context of private practice.

As briefly mentioned in the previous chapter, there are circumstances when a young person either over sixteen or considered “Gillick” competent might request therapy without the financial support or involvement of their parent. In these cases, if a practitioner considered it ethical to do so, they would contract with the client in the same way as they would were they over eighteen. For the purposes of this chapter and the rest of the book as a whole, however, the focus will be on work with children and young people where a third party is paying the fee as this is the most usual circumstance in work with this age group.

Case material: Heather and Conor—Part Four

Yasmin contacts Heather by telephone the day after the assessment with Conor to say that he would like to begin some sessions with Heather as soon as possible. Heather suggests a time later that week to which Yasmin agrees. Heather has already given Yasmin a copy of her therapy contract to look at. They agree that Yasmin will sign it and return it to Heather when she brings Conor in for his session, along with a copy of the referral form, which includes a space for Yasmin to confirm that she gives parental consent for
the counselling to take place. They agree the fee that Yasmin will pay for the sessions and Yasmin says that she intends to speak to Conor’s dad about sharing the cost of the counselling but she is not sure he will be willing to do so. They also agree that they will review Conor’s counselling together after six sessions. Heather reminds Yasmin that she will not be able to share any information about the content of Conor’s sessions with her and that what is shared at the review will only be what Conor is happy for his mum to be aware of. She advises that they will wait until nearer the time to see what form the review will take and who will be involved in it. Yasmin is happy with all of this and agrees that the counselling needs to feel like a safe space for Conor to be able to open up in. She ends the conversation saying that she just wants her happy little boy back again.

The fee

For the most part in therapy for this age group it is the parent or carer who pays the fee for the therapy sessions and who is therefore making a financial investment in the process. This leads to an important question for practitioners regarding the meaning of this investment and who has “ownership” of the sessions and sets the agenda; client or parent?

Fee is a vital element of the frame in adult counselling and psychotherapy. When a practitioner sets a fee with their client they are asking them to invest in and commit to the therapy, as well as introducing an element of reality into the process regarding their own needs, including that of needing to earn a living. Anne Gray (1994) argues in her book An Introduction to the Therapeutic Frame, that the fee, along with other aspects of the therapeutic contract represents Freud’s “reality principle” (1920) in action;

The reality is that therapists have needs of their own: they have to earn money in order to live; they have interests outside the therapeutic encounter; they have other clients; they need rest and relief—just as parents have needs of their own which may conflict with the needs of an individual child. (Gray, 1994, p. 11)

In Money Matters: The Fee in Psychotherapy and Psychoanalysis, Herron and Welt (1992) argue further to this that the fee is a taboo
subject for most therapists who feel guilt for inflicting the demand of a payment on their client. The therapist's "love" and regard for their client is not unconditional and this is demonstrated primarily via the fee charged for the session and therefore for the therapist's time and concern. They argue that this difficulty with the fee still exists in therapeutic relationships where the fee is not directly paid by the client;

In some instances the payment may be made by a parent or a spouse. Still, the patient pays because the people putting up the money expect payment of some kind—gratitude, understanding, changed attitudes—from the patient. The transaction between patient and therapist is more remote, but the payment concept is constant. Furthermore, the people paying the money may well expect an accounting from the therapists. (Herron & Welt, 1992, p. 6)

It is these expectations of payment in kind, identified here by Herron and Welt (1992) that therapists need to be aware of when working with the client and parent at the same time. When a parent brings their child for therapy, they may often have a clear idea themselves of what their child's "problem" is as well as what needs to be done to "solve" it. For example, the parents of a child with issues around eating may bring their child expecting the therapist to help their child to start eating "normally" again and gaining weight. They are expecting a change of attitude, and concern for their child means that they are hoping it will happen fast. Facilitating their child eating normally and gaining weight will most likely be the priority and often the only concern for parents. Their agenda when contracting is clear; I am paying you to use your expertise to get my child to begin eating "normally" again. Practitioners may well find themselves wanting to take a different approach to setting an agenda for the therapy, taking into account the experience of the client and an attempt, for example, to understand the underlying communication beneath the eating behaviour as a method of helping the client to regain a healthy relationship with food. Clearly, in the example of a client who is becoming anorexic and losing significant amounts of weight rapidly, it may be vital to increase their calorific intake quickly in order to reduce the risk of cognitive impairment and harm to the body and vital organs. Working
with young people where eating has become severely disordered will be covered in more depth in the chapter on working with risk further on in this book.

Similarly, if a child’s “bad” behaviour is causing distress to a parent it may be this which prompts them to look for counselling for them. This behaviour could be anything including self-harm and injury, substance misuse, or angry outbursts of shouting and swearing at their parent. Once again, the fact that the parent is paying for the session may mean that they believe, either consciously or unconsciously, that the therapeutic outcome is theirs and that therefore they should be allowed to decide what the objective of the therapy should be. They may feel frustrated when the therapist does not join with them in condemning their child’s behaviour and setting about to bring it into line, but instead makes an attempt to understand and help the child communicate their feelings in a more appropriate and healthy manner.

It may be very useful for practitioners to bear in mind that the fee in child and adolescent therapy represents a monetary exchange for the skills and expertise of the professional in working with the issues as presented by the client, rather than “ownership” of the therapeutic process and its outcome. It is important that practitioners are clear about this in their own minds when they embark on work in this field as this will allow them to retain clarity regarding their role.

Just as with adult clients paying for their own therapy, a parent paying for private therapy for their child cannot necessarily buy a particular therapeutic outcome, but they certainly can negotiate in terms of how much they are willing to pay and for how long. Since for the most part therapy in private practice does involve a direct financial transaction, the person at the paying end of that transaction holds significant power in terms of being able to decide whether or not they continue to pay for the service. For some parents this may relate to their own financial realities, although it may also reflect their need to maintain some control of the therapeutic process. Private counselling or psychotherapy is a relatively expensive regular commitment, and for some parents, however concerned they are for their child’s wellbeing and invested in helping them, they may not have the available funds to pay a fee indefinitely. This leads us to another important aspect of the therapeutic frame; establishment of therapeutic goals and length of contract.
Establishing goals for therapy

Before thinking more specifically about how long to contract to work with a client there must first be some consideration of what the goals or aims are for therapy. It may be that these have been fairly clear from the time of the initial referral. At their first contact with the therapist, the parent(s) may have a goal or goals in mind, which were then confirmed during the assessment process. For example, a parent may be looking for resolution of a specific symptomatic or behavioural issue which is troubling them or their child. It may be apparent to the therapist from the assessment process that the child is dealing with issues relating to a specific source of distress, for example, parental separation, loss of a parent through death or divorce, illness etc. and that the therapeutic work will be focussed on helping them to come to terms with this issue and find new ways of managing which are less distressing for themselves and their family. If the child is generally developing well apart from the issues which have arisen and they have an adequate support structure around them, it may be that a satisfactory therapeutic outcome can be achieved within a relatively few sessions. In this situation it can be useful to discuss with the parent(s) a contract for a specific number of sessions, and then have a review session of some kind to establish if the therapeutic goal is on course to be achieved. This type of flexible and adaptive structure allows the practitioner to develop the therapy from the assessment onwards, according to the needs of the client. First, an assessment is offered (A), followed by a fixed number of sessions (S), then a review (R), and then either an ending phase consisting of a fixed number of sessions focussing on termination and bringing the work to a conclusion (E) or further sessions and/or reviews. The following are examples of how this might look in practice:

\[ A + 6S + R + 2E \] or \[ A + 6S + R + 4S + 2E \]

The flexibility of this structure works well when practitioners find that further issues emerge as the therapy proceeds potentially requiring additional sessions. During the review which could take place by phone or in person, both with and without the client present depending on what is appropriate in individual cases, these additional issues can be discussed fully and a decision made as to how to work with them. It may be decided the most benefit will be gained by staying focussed on
the original therapeutic work and to perhaps treat the emerging issues separately at a different time. This review can also be an opportunity to discuss any issues arising from the therapy that indicate the client could need to be referred onto another service, or that work with other family members would be useful. These processes will be discussed in depth in later chapters.

Therapeutic goals and length of contract can also be less simple to negotiate than as outlined in the above. Parents do not always refer their children with issues which are arising from such definite issues. Often issues and problems have existed for a long time and it is only when a crisis occurs that children are referred for therapy.

**Competing agendas**

Therapeutic work with children and adolescents really requires therapists to think collaboratively with clients and parents to set realistic goals for the therapy. How these goals are set and what they constitute will be influenced considerably by several factors; the age and developmental stage a client has reached; their psychological mindedness or ego-functioning; the conditions they are living in. that is, whether they are well supported socially etc.; whether the work is intended to be brief or open-ended and the theoretical model used by the therapist.

In *Counselling Children* (2002), Geldard and Geldard set out four levels of goals in working therapeutically with children. These are:

- Level 1 goals—fundamental goals
- Level 2 goals—the parents’ goals
- Level 3 goals—goals formulated by the counsellor
- Level 4 goals—the child’s goals. (Geldard & Geldard, 2002, p. 6)

Considering different “levels” of goals in this way allows the practitioner to see clearly where one agenda for the therapy could dominate the goal setting process, potentially effecting the ethical basis, and the positive outcome of the work. For example, if only the parents’ goals are taken into consideration, then the practitioner may lose sight of what the child as client would like from their counselling, potentially resulting in the client feeling uninvolved in the therapy and unable to benefit from it. Alternatively, if the parent’s goals are not taken into
consideration, they may decide that their child's best interest is not being appropriately considered and that there is nothing to be gained from them investing in the therapy, and withdraw their support for the process.

Practitioners themselves will have their own fundamental therapeutic aims, largely consistent across all the therapeutic work they undertake with clients. These may include aims such as improving the client's ability to deal with emotional difficulties, raising their self-esteem, enabling them to manage their feelings and behaviours so they don't experience excessive negative consequences, amongst others. These aims are largely influenced and supported by the ethical basis of therapeutic work. An example is the principle of "beneficence", as proposed by BACP (British Association for Counselling and Psychotherapy) (2013) ethical framework, which requires practitioners to always ensure that the work they are doing is of benefit to their client. Beneficence is a useful principle to have in mind in the complexity of working with children, as it allows the therapist to always remember that the child is the client and not the parent, and any therapy must be of benefit to the child before the parent.

The fundamental aim of therapy, to improve emotional and psychological wellbeing and increase a client's ability to engage positively with their own life and the lives of others, must be at the heart of all therapeutic endeavour, and form the bedrock from which all other goals will be formed, regardless of individual theoretical or clinical models. The work of therapy, whether with children or adults, is to understand what impedes a client's ability and functioning in these areas and then to try to address these factors.

Parental goals for therapy may be very specific, and are often related to their own agenda for their children. This is exemplified in the case material at the start of the chapter when Conor's mum says to Heather that she just wants her "happy little boy" back. Parents referring their children for therapy in private practice will do so generally because they have identified something about their child's behaviour, or wellbeing, as dysfunctional or distressing in some way, and have been advised, or come to the conclusion themselves that this can best be dealt with in therapy. As discussed briefly in the chapter on assessment, parents come to therapy for their children with varying degrees of understanding regarding how the difficulties have arisen, and often with differing ideas about how they might be addressed. Many parents
understandably hold out the hope that therapy will provide some sort of magic "fix" for their child so that the troubling symptoms will disappear and may be disappointed when this does not prove to be the case.

With young children, the parental agenda for therapeutic goals can have more significance in work than with older children. Prior to puberty and the beginning of adolescence, children are unlikely to voice their own desire for therapy themselves. It is parents, or possible teachers or other adults with whom they are in contact, who will identify a problem and then refer the child either to their GP, or directly to a therapist. In this respect, the parent's agenda is vital, as without their concerns the child would not enter or continue in therapy at all. The child's goals, prior to adolescence are much harder to ascertain than the parent's and even the therapist's. Practitioners must observe closely the material the client brings to each session, particularly early on, and then use these observations to ascertain what they need from their therapy and therefore what goals to set.

Case Material: Heather and Conor—Part Five

Heather and Conor meet for their first appointment, Heather having contracted with Yasmin that they will have six sessions before reviewing the counselling. Initially Heather reiterates the agreement around confidentiality and explains to Conor that they now have six sessions together before they consider if they need more or whether they can bring the counselling to a close. Heather lets Conor know that they have forty minutes together and that he can choose how to use that time. They can talk, or he can use any of the other materials in the room. Heather explains that hopefully the sessions will help them to get to the bottom of whatever has been bothering Conor and preventing him from enjoying his activities.

The case material above demonstrates how the counsellor's agenda, and the parent's agenda at this point are the most significant in the work. Yasmin has stated that she has noticed that Conor is not enjoying activities that were previously important to him and Heather indicates to Conor that one of the goals of the therapy will be to understand what has caused this change. Heather's hope at this point is that the reasons why this change has occurred and Conor's own feelings about it will
emerge in the course of the therapy in a way that allows them to work on them together.

**Establishing goals—adolescents and young people**

As previously discussed, contracting and goal setting with adolescents and young people can be less straightforward than with younger children, particularly due to the circumstances of adolescence. During this phase, as we know, young people are beginning to do the important work of separation and individuation from their parents and attempting to establish a separate identity of their own. Adolescence can be seen as a phase of mourning the childhood attachments to mum and dad, as well as movement towards establishing new attachments outside of the family environment. During adolescence, young people are naturally less compliant with their parents’ ideas of appropriate behaviour and what constitutes dysfunctional choices and methods of managing emotions. This is shown in the following case example:

The mother of a sixteen-year-old boy, Louis, contacts a child psychotherapist regarding concerns about her son’s use of cannabis and frequent angry outbursts. In an initial phone consultation with the therapist, his mother says that her son’s use of cannabis is “excessive” and she feels strongly that he must stop using drugs altogether. Louis comes reluctantly to his first session where the therapist states that the session is for him to use to talk about whatever he likes. Confidentiality is discussed and the limits agreed upon including what will happen should the therapist feel that Louis is at risk in any respect. Louis says that he knows his mum thinks his drug use is the problem, but as far as he is concerned and, by comparison with friends, his use of cannabis is not excessive, or problematic. He likes to smoke socially as it makes him feel part of the group and accepted by his friends. Louis says that he does not like to drink or hang out with others who use alcohol as he has experienced them as aggressive and volatile, and that he therefore finds smoking cannabis to be “better” for him than the alcohol used by some of his peers.

At this point in the therapy, his mother’s goal for the therapy is clearly for Louis to stop using drugs absolutely, as she is making an assumption
based on her own knowledge and experience that this is a behaviour which is harmful and dangerous for her son to be engaged in. This may or may not be a correct assumption on her part, but as Louis does not see this as an issue at this stage, to continue with a therapeutic goal of curtailing drug use in line with the parental goal would be to alienate Louis from his own therapy. Here it is important to hold in mind that the therapist’s goal might be to help Louis understand his relationship with drugs as well as his relationships with his peers, and then decide for himself whether his use is problematic for him. It may be important for the therapist to help Louis to understand that it may take some time for him to recognise what, if any, goals he might have for his therapy, but that the space is available for him to explore this with the therapist alongside him.

It is especially important for therapists of older children and adolescents to maintain an attitude of curiosity and non-judgement. If this is not the case it may prove difficult for the young person to make effective use of the therapist and the therapy, and there is a danger they will quickly disengage. For many young people, emotional and psychological difficulties arise at a point when their energies are moving away from establishing attachments with adult or parent figures and towards peer group connections. However, since adolescents and young people are also looking for ways of understanding and coming to terms with their rapidly changing selves they often welcome the opportunity to do this alongside someone who is able to support them in this endeavour without prejudice or anxiety of their own.

When goal setting for therapy with adolescents, practitioners must hold a careful balance in terms of ensuring client autonomy while bearing in mind the concerns of the parents as referrers. Practitioners also need to bear in mind that the life aims and objectives of young people going through adolescence will not be the same as those of adult clients. It is not necessarily appropriate for young people in current times to be seeking to be settled and fulfilled in love and work as older adult clients may be striving for as their ultimate goal of therapy. Some degree of risk-taking is a natural part of the life of the adolescent and not necessarily to be seen as undesirable.

For practitioners working with clients of this age group an experience of exploring their own adolescence in personal therapy can be of enormous benefit to their clinical practice. This exploration can enable therapists to be aware of how they themselves negotiated this period
and have a sense of their own process in this respect, helping them to maintain separation when encountering the client’s own adolescence.

**Reviewing progress**

Reviews are an integral part of this therapeutic work, offering an opportunity for all parties involved in the therapeutic process to connect and communicate about it and contribute to its onward progress. If clear boundaries have been set-up around the therapy in terms of confidentiality at the beginning and communicated to all parties it should be possible to offer a review which takes into account the concerns and feedback of all while maintaining the needs of the client and the confidentiality of the therapy as paramount.

With younger children the review may take place with the child and parents together or the practitioner may wish to meet with the parents alone for part or all of the session. If the meeting takes place with parent(s) alone there will need to be a conversation with the client beforehand explaining the purpose of the review, and making an agreement together regarding what is ok to for the therapist to share with their parents. This is also an opportunity to review with the client and find out how they are experiencing their therapy and what, if anything, they would like to be different. For the parents, the review is an opportunity for them to comment on any changes they have noticed since the therapy began as well as to raise any further concerns that may have arisen for them. This can also be an opportunity for the practitioner to make further investigations into the client’s background and history if there are questions about this which have come up during the course of the therapy. At this point, discussions can take place regarding the possibility of any additional referrals, or family work. This is also the time, if appropriate, to come to an agreement for the therapy to begin moving toward the end-phase.

Just as with the initial assessment, parents can feel extremely anxious when they are coming to the review session. They may have fears that during the course of the therapy their shortcomings or mistakes have emerged, and that they will now be blamed and held to account for all they have done “wrong”. When meeting with a client’s parent(s) it can be very useful to be mindful of these fears, and aim to create an open and collaborative space where all parties can think and reflect together on how best to assist the client. It may not always be possible to prevent
a parent from feeling attacked and becoming defensive during the course of the review, but if care and attention has gone in to setting the frame for the review, just as with a therapy session, then there is more potential for keeping the meeting as constructive as possible. It can help to be open with parents about this from the start and ask them how they are feeling regarding the review and the therapy in general. This allows them to feel acknowledged and valued and can provide beneficial information about how the therapy is currently regarded by the family. If parents are put at their ease initially it can be much easier to cope further on if the session becomes more challenging.

Reviewing work with adolescents and young people

When we are working with an older child or young person the review process is still an important part of the therapy for the reasons mentioned previously, that is, to bring the various parties together in order to provide feedback and make decisions regarding the future of the work. With this particular group it may not be appropriate or necessary to have parent(s) attend in person for a review session although equally this may be something that the young person wishes to take place.

If appropriate the review can take place over the phone, and may consist of an agreement around continuing sessions or bringing them to a close. Parents of adolescents and young people can occupy various positions in relation to their child’s therapy and these are useful for practitioners to observe and take note of. The way a parent treats their involvement in their child’s therapy can provide important information about their relationship in general with the life of their child. Some parents and carers remain very much in the background of their child’s therapy throughout the process. This may be because they see their child at this stage as having a more or less separate life from them, and their respect for this means they would not want to intrude upon their therapy out of respect for their child’s privacy. These parents may recognise they have a part to play in their still partially dependent child’s life, and they are happy to support the work financially, or in any other respect if required. On other occasions, a parent’s detachment could be indicative of a general neglect and lack of interest in their child’s life beyond the willingness to pay for sessions to continue. In this respect similar behaviour by a parent can indicate very different family dynamics.
There are, however, some parents who take up a far more active role in relation to their child’s therapy and, once again, this can be indicative of the family dynamics. It can be important when reviewing the work with a parent who is very interested in the therapy to be sure that they understand the boundaries of confidentiality and are clear as to what their role is in respect of the review. Practitioners have a vital role to play in this respect and this is another area of the work which can be quite tricky to negotiate. Parents may come to the review with increasing areas of their child’s life which they feel anxious about and want addressed in the therapy sessions with their child. They may be concerned about drug use or self-harm, or about the way their child speaks or behaves towards them between sessions. When such issues arise during contact with parents, it can be easy for the therapist to feel that they must try to address these concerns, regardless of their therapeutic relevance, in order not to disappoint the parent and therefore potentially put the survival of the therapy at risk. Parents can feel extremely worried about their child’s behaviour, and may want their concerns addressed and anxiety lessened. The key point to remember is that the parents’ anxiety is not the main focus or concern of the therapy. The primary consideration must always be the client themselves and, while parents can be sympathised with in terms of the difficulties they are going through, they may also need gentle encouragement to find support for themselves with this elsewhere. This may be in their own therapy, support groups, or in their network of family and friends. Parents may be greatly helped when a practitioner acknowledges how much anxiety can be raised by having a child going through therapy, and how difficult it might feel for them to be on their own with this. Some parents do not have a good support network, or they may not feel able to discuss their child’s therapy with close family or friends, and therefore may find the offer of alternative therapeutic support most useful.

As adults and sometimes parents themselves, practitioners may find it hard to resist the seduction of helping parents to manage their anxiety, when it is the child whom they have been contracted to help. The therapist may well experience a natural identification with the plight of a mother or father who feels helpless in the face of their teen’s distressing behaviour and who look to them for help and reassurance. Therapists working with this age group are likely to be closer in age to the parent than to the client, and may even have similar concerns about
their own children. These factors can add to the difficulty in holding clearly in mind who the client is, and what the therapeutic work is, in this case. In this respect, clinical supervision provides an essential space for the therapist to reflect on these conflicts should they arise, and find the means to manage them in the therapeutic process.

Feelings of envy may also arise in the relationship between therapist and parent. Parents may see the therapist as having taken on the role of confidante for their child, usually a position they themselves have held until recently in the case of an adolescent or older child. They may feel envious of the perceived closeness between the therapist and their child, or of the therapist’s apparent skill in helping their child where they perceive themselves as having failed. It can also be painful for parents when therapists are not prepared to share their child’s confidences with them in order to make up for their loss in this respect.

In work with adolescents, the review may also be an opportunity, where it is in the client’s best interest and agreed to by them, for a family session involving parents and client in order to open up a conversation about how to best support their child within the family dynamic. During the course of the therapy, an understanding may develop regarding the ways in which the client experiences the home environment as contributing to their issues. The review can be a facilitative space where different viewpoints can be expressed, and all voices heard. This kind of review will be discussed further in the chapter on working with other family members.

**Breaks in the therapy**

Breaks are a significant part of therapeutic work in private practice in work with children and young people. Therapists often have an established practice around contracting for breaks and holidays with adult clients which may need to be adapted for work with a different client group. With younger children, who are dependent upon their parents to bring them to and from their therapy sessions, the therapy can quickly become part of the family routine. It is important to bear in mind that often this routine is very much connected to school term times, and it can become harder to manage sessions during the school holidays. This is where flexibility with regards to individual clients, and their situations is necessary. For some children, attendance outside of term time can become quite difficult and, if appropriate to the work, it can
be useful at times to see the school holidays as providing natural breaks between pieces of work, as in school counselling. It is worth noting that this may mean that child client breaks may not completely coincide with a practitioners planned breaks from adult work, and this is something for practitioners to take into account when making plans regarding projected income, or fees charged. With some children, breaks around the school holidays may not be necessary or desirable. It may be necessary to keep the momentum of the work going, and both client and parent may be fully committed to continuing the therapy inside and out of term time.

With older adolescents and young people who are still at school or college, attendance outside of term time can, again, be problematic. For many young people beginning to gain independence and autonomy about how they spend their time, the holidays can feel like their time to do with what they want, as oppose to the rigid constraints of term-time and the school or college timetable. If there is a sense with a particular client that this is the case, it may be more beneficial for the client to have a break from the therapy while they are out of school than to ask them to continue to attend, something they may experience as punitive and authoritarian. It can of course also be useful to explore these issues with our young clients. How does it feel for them to continue to attend their sessions when they would rather be on the beach or playing football? It is important for therapists to be sensitive to the difference between times when holding clients in such an exploration is useful and productive, and when it becomes potentially damaging for the therapeutic alliance. The attitude of the therapist here is vital in conveying to the adolescent client that their need for the therapy can be held in mind, as well as their need for separation. The provision of a therapeutic frame which is consistent and structured enough to provide stability and tolerable levels of frustration for clients, along with the flexibility to allow them the freedom to move away and then re-engage with sessions when the break comes to an end, can be most useful in this respect.

*Endings*

Endings are a big part of therapeutic work and need to be held in mind from the very beginning within the contract. As part of the therapy contract it is usual to talk about the process of ending and there is much in the therapeutic literature (Edwards, 1997), regarding the termination
process in therapy as well as unplanned endings and ambivalence from both client and therapist when it comes to bringing the work and the relationship to a close.

With younger children the end will usually be agreed upon by both the client, parents, and practitioner together. Ideally this will happen because a satisfactory point has been reached in the work where the client and family feel they have gained enough from the therapy process to be able to continue to move forward independently, without regular sessions. A plan may be negotiated in the ending phase to include follow-up sessions in the future to review progress following termination, or it may be agreed that the family will make contact themselves should further work be considered necessary. This will all depend very much upon how the family have found the therapy, as well as on the original presenting concerns.

There is much to be found in the literature around work with adolescents regarding the infrequency with which their therapy is brought to a satisfactory conclusion. It can be true that young people can be less willing to complete either "working through", or termination phases. Some theorists (Coren, 1996; Shefler, 2000), have suggested that for this reason, brief therapeutic interventions are more suited to those going through the adolescent stage. Shefler (2000) notes; "Many adolescents in need of therapy resist long-term attachment and involvement in an ambiguous relationship, which they experience as a threat to their emerging sense of independence and separateness" (Shefler, 2000, p. 88). It might be helpful to think of therapy with adolescents and young people as a little like a picnic. The therapist offers a space, sets out the food on a blanket and then allows the young person to interact with this in whatever way they need within the structure provided. It can be the mark of a successful picnic when a young person is able to sit down to eat and then get up and go off re-engage with friends or other aspects of their life when they have had what they needed. They may not want or be able to stay and talk about how it feels to be leaving the picnic. They know on some level that they can't stay in therapy forever, but they may also not want to say goodbye completely. To return to the picnic analogy, if they say goodbye properly you may think that they won't be hungry again and pack everything away. Many young people want to leave the therapy for now, but need to know that you, or another like you, will be available should they need to return at some point. The challenge here for therapists is to let go of some of the traditional ideas they may hold
regarding the importance of working through, and coming to a point of termination, and offer flexibility to young clients, while maintaining boundaries, and challenging acting out where necessary.

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<th>Summary</th>
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<td>- The therapy contract is an integral part of all counselling and psychotherapy work.</td>
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<td>- In this area of work, the contract is often negotiated between therapist, client, and parent(s)/carer.</td>
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<td>- Goal setting for the therapy takes place on a variety of levels. The needs of the client must be paramount.</td>
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<td>- Therapeutic goal setting needs to be flexible to take into account the developmental stage of the client.</td>
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<td>- Reviews are an opportunity to look at the progress of the therapy and receive feedback from all parties involved.</td>
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<tr>
<td>- Breaks and endings need to be discussed with all parties. Clients are encouraged to end the work with the therapist where possible although individual needs will be taken into account.</td>
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