Parent–Child Therapy

An Intervention for Building Relationships

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When parents learn that their child has a diagnosis of Asperger's Syndrome they may have many questions and concerns. Parent–child therapy, the topic of this chapter, can be a helpful intervention to parents as they try to make sense of all of the new information that they have just received from an evaluation. Through parent–child therapy, the therapist and parents work together to understand the child's challenges and explore ways to facilitate the child's social, communication, and play abilities. The goal of parent–child therapy is to provide a setting for parents to enhance their understanding of their child and to gain support. Parent–child therapy is sometimes referred to as dyadic therapy because the therapist might meet with the parent(s) or with the parent(s) and child together.

Overview of parent–child dyadic therapy

The first goal of dyadic therapy is to provide emotional support to parents who are trying to understand the meaning of the diagnosis and the myriad of feelings that can occur when the diagnosis has been made. Parents might express confusion regarding different clinical terms they heard during a conference with a diagnostician, or they feel unsure about what to do next in terms of therapies that were suggested. The second goal of parent–child therapy is to create pleasurable opportunities for the parent and child to play together, thereby facilitating the parent's understanding of his/her child. Play provides the context for dyadic work because it is through play that

children develop reasoning skills, flexible thinking, emotional understanding, and perspective taking (Leslie 1987; Piaget 1962). While children with AS may show disorganized or rigid play (as described in Chapter 2), they do like to play and can enjoy doing so with others. Finally, the third goal is for the parent(s) and therapist to identify and practice ways to develop the child's play, and relational and communication skills. These are often the skills that do not come as easily to the child with AS, and parent–child therapy offers a structured setting for the child to practice these skills.

Who provides parent–child therapy?

Parent–child therapy is most often conducted by a child psychologist, clinical social worker, licensed marriage and family therapist, or child psychiatrist. Parents will want to choose a clinician who has a good understanding of AS and knowledge of what is typical for young children in their play, behavior, and emotional development. The therapist can help parents understand what behaviors might be typical for their child's age and temperament and what behaviors might be related to the diagnosis. The therapist and parents will pull together all of the information that they have about the child and explore what strategies might be helpful to support the child's play and social adaptability. Choosing a therapist is always a personal decision and finding someone who you feel you can trust or has a good understanding of your child and who will advocate for you is essential.

When would a family benefit from parent–child therapy?

Parent–child therapy is often helpful following a diagnostic evaluation. Parents can have many emotional reactions to the diagnosis and questions about diagnostic terms (much of the diagnostic information can seem complicated). Parents might read about AS once they hear this diagnosis and then feel disheartened by the information or puzzled by the ways that their child does not fit what is in the books. Furthermore, an evaluation can generate many different recommendations, as is often the case when several different disciplines were involved in the diagnostic process, and parents may feel confused about what direction to take. Parents may have questions about which therapies should take priority, how many times a week particular therapies are needed, and who should provide the services. Or the child might participate in several different interventions, and parents find it helpful to talk with someone who is knowledgeable about the needs of the child with AS

and can think more broadly about "the big picture," and how to assess the child's response to different interventions. Importantly, the therapist should develop an understanding of the unique needs of each child in planning for and monitoring treatment.

Additionally, parents often have specific behavioral concerns, such as how to intervene when their child struggles with transitions, seems rigid, or acts out in a social situation. While a diagnostic evaluation can provide the framework for parents to begin to understand the reasons for these behaviors, the ongoing relationship with the therapist helps parents identify specific strategies to use with their child to support coping.

Sometimes following a diagnosis, parents can have conflicted feelings about whether they want to share the diagnosis with family members or friends. The therapist and parents can identify ways to describe the child's difficulties to others and respond to questions that others may have. This can be a scary, painful experience and having a safe place to explore these feelings and have these feelings normalized is important.

Parent–child therapy can also be helpful down the road after a family has digested the diagnosis and when the child is at a new point in his development. Parents might have questions about the meaning of new behaviors they observe in their child and there may be new transitions in the child's life, such as kindergarten entry. For example, there may be questions about what type of setting is best for the child, how the child will handle unstructured playground time, and what resources to request from a school district. Parents might also observe their child's developing interest in pretend play and increasing enthusiasm for bringing the parent into his play, and want to expand upon it. In addition, some parents may read about play based interventions and wish to learn more about it. As described earlier in this book, Stanley Greenspan and Serena Wieder (1998) describe "circles of communication," which is the child's ability to engage in extended back and forth interactions with another person. The field is evolving and many parents have found this work valuable as they think about what skills they would like their child to develop.

What are the roles of the therapist?

The therapist has multiple roles, including support, collaborator, model, facilitator, and advocate. The therapist provides *support* as she listens to the parents describe many different feelings about the child's behaviors and experiences. Perhaps there are uncertainties and fears about their child's development and

future. Parents might worry about how their child's difficulties will affect his ability to have friends, be accepted, and develop a positive self-esteem. Parents might observe how their child appears no different from any other child, yet at other times the child's challenges seem so apparent. As therapy progresses, parents may want to talk about how the child's difficulties affect other children in the family. For example, parents might feel unsure about setting different expectations and making different accommodations for their child with AS. Often it can seem overwhelming for parents to take in all the new information about their child with AS, plan for and schedule therapies, and then find the energy and time to meet the individual and changing needs of other children in the family. Each of these issues can surface at different times during the therapy.

As *collaborators* and *shared observers*, the therapist and parents are developing an understanding of the child and together identifying goals for intervention. They may share their observations of the child and find ways to intervene with challenging behaviors or provide predictability that helps the child feel calm. For example, a child who is having difficulty separating from a parent when taken to preschool might benefit from a Social Story that includes pictures and a simple narrative of a consistent separation routine (Social Stories were developed by Carol Gray for use with older children with AS and recently adapted to address the needs of younger children). A child who tantrums when he cannot view a favorite video may respond positively to an activity board that provides a schedule for the day and several options for favorite activities. As another example, a parent may read about behavior modification techniques and have questions about how these techniques might be used with their child. Finally, the therapist and parent might identify what to do during a play date or outing with friends when the child acts out.

As a *model* for the parent, the therapist works with the child to develop different strategies that facilitate the child's relational and play skills. At times, the therapist might describe to the parent what has been helpful for the child. For example, the therapist might say, "I think I am talking too fast to Sam. I am going to pause, speak more slowly, and use fewer words." Another example might be, "He seems better able to play with us when we build on an experience that is known to him, like going to a carwash." These reflections can help the parent begin making sense of what they are observing as well as provide helpful interventions for use at home. This process provides parents with concrete strategies to practice with the child. In subsequent meetings

with the therapist, the parent shares his/her perceptions of the effectiveness of these strategies.

As a *facilitator*, the therapist supports the parents as they play with their child and fosters mutual pleasure in doing an activity together. The therapist can identify what the parent is doing that facilitates the child's sustained engagement and reciprocity, and offers suggestions to move the play along and help the parent and child converse. The clinician encourages the parents to share their observations of the child during play. It is useful to set time aside during the session to share these observations. This shared communication creates a process for building play and interaction skills.

As an *advocate* (resource), the therapist can help the parents determine which services may be most helpful, their availability, and ways to obtain them. The therapist may also consult with school staff and/or other professionals to develop a shared understanding of the child and implement consistent interventions. For example, the therapist can educate a teacher about the child's tendency to feel anxious when there is unstructured time or when routines change.

Table 7.1 Role of the therapist in parent–child therapy

- Support: clarify the diagnosis; explore parents' questions, concerns, and feelings about the news
- Collaborator and shared observer: develop understanding of the child's individual needs and challenges and identify interventions that are helpful to the child
- Model: therapist interacts with the child to identify strategies that facilitate the child's relational and play skills
- Facilitator: foster attunement to the child and sustained engagement in play
- Advocate/resource: referral to specialists in the area of Asperger's Syndrome in young children and build rapport with other clinicians/teachers involved in the child's care (provide consultation to schools as needed)

To illustrate these multiple roles, let's look at this example of a therapist beginning to work with a family in the context of parent–child therapy. Brice, age three-and-a-half years, and his parents were referred following a

diagnostic evaluation that showed that Brice had good cognitive abilities but difficulties initiating social interactions with peers and using language in a conversational manner, and some rigid routines with play. He was scheduled to enter a regular preschool program several mornings per week as well as a communication based preschool program to provide more focused attention to his needs. His parents had requested assistance with behavioral issues, and strategies to support Brice's play and interaction skills. They had observed that he had lately seemed irritable and easily frustrated and while he sought them out for play, they felt uncertain as to how to play with him. As a first step in the therapy, information was gathered about these issues and ongoing questions about Brice's diagnosis were explored with the parents. Together, the therapist and parents observed Brice's play to learn more about his strengths and challenges. Dyadic sessions were scheduled once every other week. The therapist observed Brice in his preschool and met with his teachers to learn more about what they needed help with. The teachers requested help understanding the meaning of his screaming behavior and how to intervene; they were concerned when he wandered in and out of the classroom and had observed that he did not play with other children. After getting to know Brice and his family the therapist was able to assist the teachers to develop strategies to engage him and decrease negative behaviors.

As the facilitator, the therapist worked with Brice and his parents to develop his joint attention, communication, and pretend play skills (e.g. using toys to develop a story). The therapist modeled how to match Brice's pace and provide structure when he seemed not to know what to do next. When Brice was frustrated and screamed the therapist and parents could discuss reasons for this behavior, how it also occurred in other settings, and ways to intervene. The therapist provided support to the parents when they expressed how helpless and distressed they sometimes felt when he screamed. For example, in one session Brice neatly arranged a set of animals in a line on a table, with each animal facing forward and equally spaced. The therapist, as facilitator, suggested to the father that he and Brice offer each animal a piece of food on a plate. He removed one of the animals from the line in order to find some "food" and Brice shrieked and stomped his feet. When his father reported that he had seen this type of play before, the therapist suggested how hard it was for him to be flexible in taking in new play ideas. Sometimes even slight variations were so troubling to Brice that he reacted by screaming. Through experiences like this one the therapist and parents began to understand also that Brice did not always have the verbal abilities to manage his anxiety and

negotiate a solution. The father gently wrapped his arms around Brice and simply returned the animal to its original location and offered it a piece of food. Brice visibly calmed and then repeated his father's actions with a piece of food.

Brice then moved away from the table to resume a familiar activity of putting cars into a garage and his father followed, stating that Brice had found the cars to play with again. Brice's father had intuitively recognized that Brice needed the familiar and comforting rhythm of the cars to reorganize, and perhaps to have time to assimilate what had just happened. As shared observer, the therapist and Brice's father learned the value of giving Brice the freedom to protest, time with safe limits to regain control, and permission to use comforting routines to reorganize. The challenging next step would be to develop these skills in the context of interactions with peers. This type of parent–child work lays the foundation for social interactions with peers.

As you can see the role of the therapist is multifaceted, as is the role of the parent in the work. The work together can empower parents to not only understand their child but also learn ways to foster their relationship.

The nuts and bolts of parent–child therapy

With a picture now of what parent–child (dyadic) therapy can look like, this section identifies more specifically some of the issues which the parent and therapist explore within the parent–child therapy. As noted, the first goal is for the therapist and parent to develop a shared understanding of the child in the following areas:

1. The child's language use in terms of complexity (sentence structure, vocabulary), range of ideas, and communicative intentions (share information, ask questions, express intentions, invite, show).
2. Language processing capabilities.
3. Use of nonverbal behaviors for social referencing purposes.
4. Level of symbolic play, thematic organization and capacity for representation.
5. Ability to initiate and participate in turn taking routines; complexity of turn taking routines.
6. Emotional expression (expressed pleasure in shared activity).

For example, some children will have strong expressive language skills, but the ability to participate in turn taking play might be an area of difficulty. Another child might use language for a variety of purposes, but then insist, for example, that he always be the "chef" in a restaurant and the partner is always the "patron." The child then proceeds with his plan to be the "chef," not really attending to the partner's responses to guide what he should do next. As another example, the child might respond with interest to what the partner suggests in play, but then when the partner waits for the child to carry the idea further, the child continues alone with the same play ideas but does not actively engage the partner. During a session with the parents alone or at the end of a session with the child, the therapist might describe what these different concepts mean, why they are important, and how they take on different characteristics at different stages of the child's development.

In addition, the therapist and parent may explore when the child appears confused or disorganized (which often presents as unrelated statements, phrases from a favorite video, increased motor activity, and "crashing" of toys). Together they try to assess what factors might be contributing to the child's confusion. As the therapist and parent work together at interpreting the child's behaviors they may begin to explore some of the following questions: Is the adult speaking too quickly? Is the adult allowing adequate time for the child to process the verbal input and respond? Is the adult introducing play that is too complicated for the child to grasp? Is the adult introducing too many new ideas into the play? Is the adult asking too many questions? Might the adult be more intrusive than facilitative? In sum, these questions guide the therapist and parent to consider how the child is processing information and responding in both negative and positive ways. The therapist and parent can discuss their responses to these questions to develop a working understanding of why and how the child gets stuck. In this way the therapist and parent can think together about the next step, helping the child reconnect and re-organize.

It is also important for the therapist and parent to consider the underlying meaning of the child's behavior so that the parent can anticipate what situations might be difficult for the child. For example, the child who runs into other children in the play yard might be expressing confusion about how to join a group of peers; a child who fails to comply with the teacher's directions to "clean up" may be distracted by the noise and activity of busy classroom clean-up time or not know what is expected by "clean up." A child who rarely initiates play or conversation with another child might be

confused by the unpredictable social world. The therapist and parent can discuss ways to reduce the child's confusion in these situations and provide an environment that supports self-control and development of important social skills.

Table 7.2 summarizes the goals of parent–child play that will be explored in more detail in the next few sections of this chapter.

Table 7.2 Goals of parent–child play

- Develop an understanding of the child's capabilities and challenges
- Develop child's capacity for bringing ideas into the world of play and interactions with the parent
- Foster mutual pleasure in playing together
- Foster communication skills and emotional expression
- Parents learn how to interpret child's behavior (confusion, rigidity) and develop ways to cope with this behavior during play together

Strategies for helping children with beginning stages of play

There are many approaches to engaging children in play, and dyadic therapy creates an opportunity to explore different ways to engage your child and help him expand and elaborate his play skills. Since the focus of intervention is helping with play skills, the therapy also helps parents begin to understand the frustrations peers may feel when trying to engage their child. The experience parents have trying to "play" with their child will ultimately help them to figure out what the child will need from other care providers when looking for support for the child. A good starting point for some children is to allow the child to choose a toy and observe the child for a few moments to get a sense for what ideas he expresses and how he uses the materials (e.g. pretend play, or scripted activities such as replaying scenes from a video). The therapist may join the child by offering a simple comment about what the child is doing or imitating the child's action in some way. Sometimes it is helpful to tell the child "I am going to play with you. Let me see what you are doing" so that the child is prepared for the therapist's participation (simply sitting down next to the child may be too subtle, or immediately directing the child to perform a specific action may silence the child). Another strategy that can be helpful for some children is to offer a choice of two activities. This can sometimes help to

focus a child who seems overwhelmed by too many appealing items or not quite sure how to begin. The next steps, then, are to elaborate and expand the child's play by adding a new, but related, idea to what the child has introduced. Others have written about this strategy in the areas of special education, language development, and general child psychology (Greenspan and Wieder 1998; Kohlberg and Fein 1987; McDonald 1989). Elaboration often takes the form of slight variations, and the most helpful interventions for the child with AS are those that do not aim to do too much at once. While expanding the child's play it is important to maintain attention to simplicity, structure, and pace. The following case illustrates how elaboration and expanding a child's play might occur in the context of parent–child therapy.

Timothy was a five-and-a-half-year-old boy who had been identified by the school psychologist as having features of AS. His mother was interested in more information about this diagnosis, his development, and interventions that would be most appropriate for him. She was particularly concerned about his disruptive behavior in the kindergarten classroom (such as hiding under tables and refusing certain tasks) and socialization difficulties. She was referred to parent–child therapy to help her address these concerns. During a play session together, Timothy chose a set of plastic bugs to label and move along the floor in a somewhat repetitive manner. His mother observed that he typically played in this way which was making it difficult for him to play with peers who were more interested in creative play. Since he had earlier shown interest in putting cars down a Fisher Price slide, the therapist suggested that the bugs might like to go down the slide. He smiled at this slightly silly idea, seemed to consider it for a moment, and then readily participated. The therapist counted "one, two, three" for each bug as it went down the slide and then ended with a "hooray!" He smiled broadly and joined in by handing bugs to the therapist and waiting for her to repeat the routine. This routine is fairly simplistic for a five-year-old, but the predictable and familiar scenario and salient verbal cues provided a comfortable starting point. The therapist continued the session by using the same set of bugs to act in different ways with other toys, such as going for a ride in a car and playing hide and seek. The goal was to expand Timothy's play repertoire by introducing one new idea at a time and assessing his responsiveness to these small shifts. Later in the session, when the therapist paused to see what Timothy might come up with next, he suggested that the bugs again go in the cars. The therapist playfully suggested that the bugs seem to have fun in the cars and readily joined in (rather than redirect to something new because they had done the same

sequence earlier), but again added a slight variation to the theme (it had begun to "rain" and the bugs were getting "wet"). Timothy appeared confused when the therapist altered the scenario, as his verbal responses to the therapist were unrelated to the therapist's questions. The therapist concluded that perhaps her suggestions were more abstract than Timothy could assimilate and that he needed more practice with simpler themes and interaction demands.

During a subsequent individual session with mother, the therapist talked about the information gathered about Timothy after several sessions with him (specifically noting his responsiveness to structure and play that incorporated his interests). They began to understand better his world of play and the ways that he found play with others pleasurable. They also began to identify why he might be disruptive or uncertain about how to respond to the other children in the classroom. Timothy's case is a good example of how parent–child therapy can assist parents in finding ways to develop these important skills.

The important role pace plays for building play

Young children with Asperger's Syndrome are confused in peer group settings, often because other children play and interact at a fast pace.

The child with AS often needs the parent and therapist to start at a slow pace as they begin to guide the play and simplify for the child what the child can do to follow. The following example shows how the therapist models this technique for the parent. An almost five-year-old boy, Brian, and the therapist were "heating" a small plastic doughnut in a stove over and over again, when Brian commented that the doughnut did not seem to stay "warm." The therapist suggested that the stove (which in this case was a chair) was broken and they needed to come up with a way to "fix it." Together the therapist and Brian fixed the stove (using small tools that Brian had located nearby) and again "heated" the doughnuts, but without success. Brian and the therapist repeated their frustrating attempts to heat the doughnut in the stove that seemed always to "break." Brian appeared to take genuine pleasure in solving the problem together (he and the therapist each took a turn to call a "repairman," and then a second "repairman" when the first seemed unable to fix the stove). The play continued in this way for quite a while, with numerous repetitions of the same idea and then slight variations (need more "nails"). This child, who had attachments to unusual objects and seemingly little imagination, could readily participate in mutual problem solving and joint attention (fixing the stove together), shared emotion (frustration when the

efforts were unsuccessful), and interest in a new idea. For this child, there were several key factors that allowed him to maintain shared interest, take turns, and enjoy creativity in play. The therapist did not rush him, remained comfortable with his pace, and allowed for repetition. Not all sessions can go this smoothly but they are rewarding when they do!

What happens when the child gets stuck?

As noted, it is common for the child with Asperger's Syndrome to develop an obsessive interest in a television character, video program, or ritualized way of playing with certain toys. The child's play may consist of replications of parts of these programs, but these are often not spontaneous and the child may not add their own ideas. The parent might misconstrue the child's play as imaginative when in fact it is a reenactment of a story plot or theme. It is easy to understand how a parent or a teacher might have this point of view, as it is typical for children to incorporate popular characters into their play (e.g. Cinderella, Darth Vader). There are several ways to work with the child on these issues. First, the therapist can help the parent observe and understand the differences in how the play carries out for the child with AS. Then, to begin to broaden the child's repertoire, it is helpful to avoid providing the child with the commercial props and products that accompany a particular character or movie. Second, the therapist and parent create opportunities for other types of play by introducing experiences that are familiar to and enjoyable for the child, such as family outings (visit to an ice cream parlor, visit to a zoo). The child may require explicit cues and more active structuring from the therapist/parent to know what to do. Explicit cues might include props that give meaning to the scenario, such as a cardboard box labeled as an ice cream store and empty ice cream sandwich cartons. Blocks can be used to build a "zoo." Sometimes it is helpful to focus on the constructive aspects of play such as placement of figures and blocks (careful attention given to where the zoo "entrance" might be or where the "lion's den" is), as this is often easier for the child with AS to do. Immediate demands for novelty and true make-believe may be too difficult. In this way the therapist/parent establishes a common focus of attention with the child, partnership in play, and enjoyment in doing a new activity together. These are the core principles of parent–child therapy.

What happens if my child acts like he does not want to play with me?

The child's movement away from the parent or therapist might be his way of expressing confusion about how to create a play theme and share ideas about a new story. We sometimes observe that the child with AS turns his back on the parent and plays alone. A child named Todd had a tendency to separate from his mother and "crash" toys together or repeat the same actions when he was confused by the social interaction demands of play. Todd's mother was perplexed by these behaviors and would attempt to help him by making many different suggestions or asking questions, which seemed too overwhelming for Todd. To reengage him, the therapist coached Todd's mother to offer two simple suggestions for the toys that he was using. With the therapist's guidance, Todd's mother helped him create a "library" (out of blocks) for small figures, and she encouraged him to decide where the "doors" and "bookshelves" should go. Todd's mother reported that going to the library was a favorite activity that they shared together and the therapist encouraged her to bring those experiences into his play. Todd's mother helped him identify which "videos" the figures might want to check out from the library and view at "home." As Todd used these toys to play out scenarios that were familiar to him, his mother introduced several new elements to the play to vary this familiar theme in small ways. With the therapist's support, she provided structure for Todd (such as clear cues for turn taking, rephrasing Todd's statements, pausing) that helped him remain engaged with her. She also practiced how to maintain a balance between allowing Todd to direct the play and follow some of her suggestions.

At a subsequent session, Todd began to throw dinosaurs on the floor and disengage from his mother. Todd's mother saw that he needed help to develop an idea and she suggested that there was a "terrible storm" that had knocked the animals over. She provided animated gestures to show her excitement at what might happen and Todd decided that he needed to "hide" the animals from the storm. Over these two sessions, Todd enthusiastically joined into this play scenario and practiced critical aspects of interactive play: monitoring a partner, reciprocal play (first you do, then I do, then you do it a little bit differently and I do it a little bit differently), and maintaining interaction.

Parent concerns that commonly surface during parent–child therapy

The work that the therapist and parents do together with the child can yield new knowledge about the child's challenges and insights into avenues for intervention. Through the dyadic work, parents can begin to feel some control over what was previously so perplexing. At the same time, there are many feelings about the child and the experience of parenting a child with unique needs that will surface in the process of the dyadic work. Understanding your child's diagnosis requires patience and reflection, a process that can sometimes seem overwhelming. All of these responses can be explored with the therapist. The therapist may also suggest individual or couples therapy as a way for parents to gain additional support for themselves as individuals and as a couple. Individual therapy can help parents explore feelings that might surface about their own childhood and identity as a parent. Talking with someone about these complicated feelings can be empowering. Likewise, couples therapy offers a setting to clarify different perceptions and needs and identify ways for parents to support and understand one another.

How long might parent–child therapy continue?

There is no specified period for parent–child therapy to occur. The duration can vary according to what questions parents have and what they find helpful for themselves and their child with AS. As noted previously, it is often helpful for parents to have an ongoing relationship with a therapist who can observe and get to know the child over time so as to identify changing needs and adjust intervention plans. For example, following the initial diagnosis, parents might meet once a week or once every other week with the therapist to clarify diagnostic information, discuss parents' behavioral and school related concerns, and begin to address the specifics of parent–child play. In some cases, the diagnosis is not new, the child has received several interventions (occupational therapy, specialized preschool program), and the parents are interested in pursuing parent–child therapy as a way to help the child with this (in many cases) unexplored area of the child's development. Regular sessions are helpful to maintain continuity as the parent pursues new ways of thinking about the child and a different way of relating to the child (through play). There are other factors to consider when setting up a therapy schedule and the parents should feel comfortable to discuss these with the therapist. These might include the child's daily school and therapy routine, cost of the

therapy, and parents' availability when there are other children in the home or both parents work outside of the home. Sessions might taper to once per month, or once every six months, to monitor the child and provide ongoing support to the parents.

How do I know if parent–child therapy is helpful?

This question is an important one as you initiate any type of therapy with your child. One aspect of parent–child therapy is ongoing discussion with the therapist of the child's strengths and challenges, what new skills are emerging, and where help is needed. You can ask yourself several questions to determine if the therapy is helpful to you: Do I feel supported in the process of understanding my child's diagnosis and needs? Am I learning how to support my child's development? Is my child developing important skills in play and communication? Importantly, parents may find different aspects of the therapy helpful at different times.

What if it feels too overwhelming to be in the same room with my child and the therapist?

Sometimes parents may feel overwhelmed by the challenges that can arise when playing with their child, or parents may feel that they do not know how to play. It may sometimes seem like the therapist knows exactly what to do. It is important for the parent to feel comfortable to express his/her reluctance to remain in the room. Most likely the therapist experiences the same challenges with the child and a discussion of these challenges can bring new insights into the child. Parents may also find it helpful to talk with the therapist about what it is like for the parent to have these feelings.

Conclusion

Parent–child therapy provides a place for parents to sort out their confusions about their child's challenges and uniqueness, receive support for the many different issues that arise, express worries, and, importantly, share hope for what their child can accomplish and take pride in who their child is. This author's work with children and parents has brought to life the many positive steps that young children with AS can take in learning important social and play skills. Through ongoing dialogue between the therapist and the parent and shared observation of the child, parents gain knowledge about their child

and learn ways to facilitate their child's development. This process can be very rewarding to the parent who often asks the question, "What can I do to help my child?"