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Introduction

For most children and adolescents, friendships are vital contexts promoting social, cognitive, emotional, and moral development (Selman and Schultz, 1990; Piaget, 1965; Sullivan, 1953). Youths who lack adequate interpersonal competencies, however, enter into vicious cycles of rejection and isolation, often losing critical developmental opportunities. Further, poor peer relationships in childhood and adolescence are a risk factor for future psychopathology and adult criminality (Parker and Asher, 1987). Therapy with dyads of children who have had chronic and severe difficulties relating with peers can foster the growth of the interpersonal competencies they need to make and sustain friendships and, consequently, to participate more fully and successfully in their social world.

The one-therapist–two-children therapeutic modality has a surprisingly short history. The first documented efforts to conduct dyadic therapy did not appear until the mid-1970s (Mitchell & Levine, 1982; Fuller, 1977; Bender, 1976; Birnbaum, 1975). These early approaches derived from principles of individual child psychotherapy; for example, children with similar traumatic issues were paired with the hope that each would gain support and insight through the sharing of personal histories (Antze, 1976). Over the past 20 years, a handful of reports have emerged describing variants of dyadic therapy called duo-therapy and peer psychotherapy. These variants are used with specific age groups and in particular settings, such as day care centers or child guidance clinics (Appelstein, 1993; Mitchell & Levine, 1982; Mehl & Petersen, 1981). In general, these models extend psychodynamic, cognitive-behavioral, or information processing theories to a dyadic therapy.

One form of dyadic therapy, called pair therapy, has been relatively well documented and successfully implemented in multiple contexts, with a broad spectrum of children and adolescents manifesting a variety of disorders (Selman, Watts, & Schultz, 1997; Selman & Schultz, 1990). In contrast to forms of duo-therapy that rely on adult-directed discussions, social skills training, or psychoeducation, pair therapy focuses on the interpersonal competencies youths employ during sessions as they develop a relationship with one another over time. This dyadic modality is overviewed in this chapter.

The Goals and Applications of Pair Therapy

The primary goal of pair therapy is to foster the growth of the interpersonal competencies, in both thought and action, that children need to form and maintain healthy, close relationships throughout life. The modality is especially suited for promoting the capacity to coordinate social perspectives, a social cognitive capacity that underlies such skills as resolving conflict, sharing experiences, cooperating, empathizing, and collaborating (Selman & Schultz, 1990).

The nature of the everyday social functioning of the children referred for pair therapy suggests the starting point and goals for each pair. For children with severe disorders, such as residual autism or broad-spectrum developmental delays, pair therapy is primarily a skill-building approach, helping them become less impulsive in their interactions. Such children need the most basic friendship skills: the ability to work and play in a shared space, to restrain egocentric and aggressive impulses, and to both tolerate and enjoy the presence of a peer.

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For children who are less constrained by the limitations of severe cognitive and communicative deficits, but who nevertheless have great difficulties making and keeping friends, pair therapy is used to foster complex interpersonal understanding and skills, such as reciprocity and mutuality. In general, the pair therapist fosters progressively accurate and more caring perceptions of and balanced concerns for the needs and wishes of both the self and the other peer.

The specific goals of pair therapy also depend on the context in which the treatment is offered. In the residential treatment setting, for example, pair therapy may have the additional goal of positively influencing the social climate of the therapeutic milieu by fostering the psychosocial development of the youths in residence.

In public school settings, pair therapy (also known in schools as pair counseling) may be adapted as an early intervention for youth who do not yet have psychiatric disorders but who are nevertheless showing early signs of school failure, conduct disorder, and problematic interpersonal relationships. The challenge for such youths may not be learning how to make friends under ordinary circumstances, but rather how to manage and make sense of their friendship in relation to dangerous and risky environmental conditions (e.g., violent neighborhoods, easy access to addictive substances, health threats such as AIDS, etc.) (Selman et al., 1992). With such children, pair therapy can operate as a preventive intervention against negative life consequences that result from risk-taking behaviors such as dropping out of school, fighting with peers, using drugs and alcohol, engaging in unsafe sex, etc.

Pair therapy can also be employed strategically to support children during specific transitions or in relation to certain social forces. The move from elementary to junior high school or from junior high to high school, for example, are points of vulnerability in development, and pair therapy can strengthen the readiness of youth to manage what will certainly be the upheaval in their social supports during such transitions. Finally, pair therapy can help children take the perspective of children from other cultural, class, or religious groups in order to ameliorate group-based prejudices, hatred, and intergroup misunderstandings (Karcher & Nakkula, in press).

Indications and Treatment Planning

In day and residential treatment settings, pair therapy is indicated for children, with a wide range of disorders, who have marked difficulties getting along with and are relatively isolated or withdrawn from peers. Children who lag behind their peers in their ability to coordinate social perspectives and to resolve interpersonal conflicts, who tend to be overly aggressive or passive in their interactions with peers, and who lack basic communicative competencies are likely to benefit from this modality. In addition, children who can make friends but generally cannot sustain friendships are good candidates for pair therapy.

For children with severe psychiatric disorders, pair therapy is not a substitute for individual or family therapy or other interventions, but can be an important piece of a broader treatment plan. Individual therapy, which may address thoughts and feelings about peer relationships, does not provide direct assistance with social functioning with peers. Children's interpersonal problems are typically manifest when young people are in therapy *with* a peer, and pair therapy can thus complement the more reflective individual work with the specific goal of promoting interpersonal competence.

The decision as to which type of socially based intervention a child may need—group or pair therapy—requires an assessment of the social capacities and needs of the referred child. Like group therapy, pair therapy offers the therapist the opportunity to observe the child's relational difficulties and strengths directly as they happen. Therefore, the therapist can intervene when difficulties arise. Pair therapy differs from group work, however, in a variety of important ways. Pair therapy is better suited than is group therapy for helping children learn how to participate in relatively intense peer relationships, which are not generally developed in group therapy. In pair therapy, children experience each other's actions or lack of action directly, and have repeated opportunities to gain perspective on themselves through the eyes of another. Conflicts and misunderstandings, for example, have a direct impact on a specific relationship, not on a number of relationships or, in the case of group therapy, the whole group.

On a more functional level, pair therapy provides a therapeutic structure that is particularly well suited for children who are overstimulated or overwhelmed by group therapy. These children may find pair therapy a manageable interpersonal context, despite its intensity. Certainly not all children require pair therapy; some—for example those who need a group setting to work on such skills as group decision making and social problem solving—may benefit more from group therapy.

Matching Pair Partners

When matching pair partners, therapists take into account the gender; interpersonal maturity; interpersonal style; existing relationship between the children; and, to a lesser extent, their personal interests. Children are almost universally matched with same-sex partners because through early adolescence children normatively develop the capacities for making and maintaining intimacy in relationships in close, same-sex friendships (Sullivan, 1953). Furthermore, the different ways in which boys and girls manage intimacy and autonomy needs in childhood (Watts, 1997) can add a level of complexity to pair therapy, which is already complicated by the individual relational difficulties of the participants.

The next consideration in matching is the interpersonal maturity of the candidates for pair therapy. The goal is to identify and pair children who function at roughly the same levels of interpersonal thought and action in peer relationships. The therapist assesses the children's reflective capacity to coordinate social perspectives and to regulate their needs for intimacy and autonomy in relationships. Social perspective coordination involves differentiating and integrating the points of view of self and a significant other person through an understanding of the thoughts, feelings, and wishes of each person. Research on social development has revealed five perspective coordination levels, ranging from undifferentiated, global perspectives on self and other to differentiated and hierarchically integrated perspectives on self and other. These levels are: Undifferentiated/Egocentric, Differentiated/Subjective, Second Person/Self-Reflective, Third Person/Mutual, and Interdependent (Selman, Watts, & Schultz, 1997).

Perspective taking is a necessary condition for adaptive social behavior but not a sufficient one. Children often act at levels that are below their social-cognitive competency to understand social situations. In order to match children in pair therapy, therefore, it is necessary to assess the range and predominant levels of their interpersonal action. In brief, two fundamental social processes characterize an individual's interpersonal actions: *Intimacy processes* foster closeness and connectedness between self and the other; *autonomy processes* foster clear boundaries delineating the needs of self and other as separate and distinct. Intimacy and autonomy functions are operationalized in the constructs of *shared experience* and *interpersonal negotiation strategies*, respectively. Research has identified five levels of shared experiences and interpersonal negotiation strategies that correspond to the perspective-taking levels mentioned previously: Impulsive, Unilateral, Reciprocal, Compromise, and Collaborative (Selman & Schultz, 1990). Matches for pair therapy are made with children with roughly the same range and predominant levels of interpersonal skills.

The final key consideration in matching pairs is the children's predominant interpersonal styles. Children referred for pair therapy tend to have trouble making friends either because they are overly aggressive and bully others or because they are overly submissive or withdrawn and tend to be victimized. Children with these opposing styles are paired because the tension between contrasting interpersonal orientations usually becomes a catalyst for growth toward a more balanced interpersonal orientation. Neither child can remain rigidly assertive or submissive if the relationship is to be sustained, and thus both must learn new strategies and gain flexibility in their use.

In general, it is not advantageous to pair children who already have a solid relationship, although pairing children with shared interests sometimes helps children feel motivated to start pair therapy and helps them form an initial bond with one another. Conversely, children who have a long history of conflict or who are unlikely to find anything they would like to do together are

not an ideal match. In this respect, pair therapy differs from peer mediation, a technique gaining popularity in public school conflict-resolution programs.

The Initial Session and Activities in Pair Therapy

It can be very useful to have a brief individual meeting with each child prior to the first pair session. In this meeting the therapist describes pair therapy and its goals, explains why the child was referred, to tells the child who the pair partner will be. Also, the therapist answers questions. When the pair is brought together for the first session, the pair therapist explains that pair therapy can be a lot of fun, but that it is not always easy because it involves working out problems with one another. The therapist explains that several rules are necessary for pair therapy: (1) The pair must stay together during sessions and throughout the planned course of treatment (i.e., until the end of the school year or for a specified number of session) (2) the pair cannot use physical force with one another or the therapist and (3) they cannot destroy property. Other rules may pertain to the specific site where pair therapy is being conducted, and the children may wish to generate some rules of their own. The pair therapist explains confidentiality—the agreement that whatever is said or done in pair therapy remains private to the three participants and the therapist's supervisor. Finally, the children should be informed that, if one of them is absent on a given day, the other child may meet with the therapist so that one child does not lose out because of the other's absence.

Pair sessions are typically of the same duration as individual therapy sessions (i.e., 50 minutes), but the length of a session may be shortened, depending on the quality of the interactions. Most pair therapy sessions start off in the therapy room with the selection of an activity, as the following interchange illustrates.

T.J.: I want to play Legos.
Paul: Uh-uh, I'm gonna draw.
Therapist: Remember, we promised to decide together what we would do. How can you two work this out so that you both get to do something you want to do?
Paul: Maybe we should do something different that we both like.
T.J.: Well, I'll play Legos today if we can draw next time.
Therapist: Paul are you willing to draw next week if we play Legos today?
Paul: Yeah.
Therapist: I really like how you were able to work that out, and T.J. that was very nice of you to offer to let Paul choose the game for this week. The Legos are in the game box.

From the standpoint of the therapeutic process, the actual activity that is chosen by the pair is less important than the way the pair decides on activities. The choice of an activity is the first context for negotiation during the pair session, one of many opportunities to develop and refine critical interpersonal competencies. The therapist may intervene during this process by using the techniques described in the next section. In addition, the therapist ensures that the activity chosen is safe and within the guidelines already outlined. Beyond that, the only limits to activities are the imagination of the participants and their capacity to engage in them together.

In pair therapy, children may play board games, do athletic activities, create artwork, watch videos, go on outings, spend their time talking, and so on. Over time, most pairs tend to find a favorite activity that they enjoy together and return to. This is especially the case when, in their relationship, the pair has been exploring anxiety-provoking interpersonal territory.

Most games may be used in different ways, depending on the children's interpersonal maturity and styles and their history with one another. Positive shared experiences, reflection, and interpersonal skill development are the priorities rather than competence at any particular activity or specific rules for play. The key for the therapist is to meet the children where they are and help them move toward increasingly mature, verbal, organized, and controlled activity.

Depending on the maturity of the pair, special activities, such as field trips, can afford opportunities for some pairs to plan together and to experience their relationship in the world beyond the therapy room. The therapist must first assess

whether the partners can manage such an activity and consider whether it would be a useful experience. If the pair wishes to do something together outside the therapy room, the activity should be planned in advance and be an activity they can agree upon and do together. Meeting in the therapy room to touch base with one another and meeting again at the end of the session to discuss how things went is also helpful. These guidelines keep the focus on working together, organizing behavior, reflecting on interactions, and ensuring safety.

Therapeutic Processes and the Therapist's Role

The process of pair therapy, given adequate time and proper supervision, evolves through a series of phases. Initially the children try to figure out how to interact in the pair. So they begin by sizing each other up and, typically, settle quickly into a pattern in which one of the children is the leader. This creates a temporary equilibrium, which later breaks down when conflicts arise between them. When the more passive child feels safe enough in the pair to assert his or her needs, these assertions, with the support of the therapist, typically lead to a restructuring of the pair's power relationship. This cycle may repeat many times over the course of a year, with the goal being that the children become able to establish an increasingly effective and balanced pattern of functioning.

The pair therapist focuses his or her attention on these dynamics between the pair partners. It can be challenging for some therapists trained in individual psychotherapy to shift their focus from the adult-child relationship to an emphasis on the peer relationship. New pair therapist often report initially that they feel their role is peripheral as the children develop their relationship. Pair therapists, however, are critically important to the process of relationship development. Children who have had chronic difficulties getting along with peers require the careful guidance and support of the adult therapist to benefit from peer interactions that would generally sour outside the structured pair therapy context.

The pair therapist's first task is to set a positive tone and to explain the goals and guidelines of pair therapy so that the pair partners feel it will be a safe and enjoyable experience. Some troubled children find it difficult to simply tolerate being with a peer and an adult in a novel situation. The therapist helps the partners find initial activities, if necessary, to help the youth tolerate their anxiety. Throughout the course of pair therapy, the therapist helps mediate conflicts that might otherwise become overwhelming for the youths. There may be times when the partners refuse to return to pair therapy and, if so, it is critically important that the therapist understand the dynamics so that he or she can facilitate the return to the pair. In these ways, the therapist acts to hold the partners together until they are capable of doing so themselves.

In general, pair therapists strive to help the partners recognize and acknowledge one another's points of view and to translate that understanding into correspondingly mature actions. The therapist's goal is not to provide solutions to conflicts between the partners, but rather to have the partners develop strategies for resolving their own conflicts. The therapist does this by helping the children work just beyond their current level of functioning. The therapist's role evolves, therefore, in tandem with the pair's shifts toward more complex perspective taking, new social competencies, and greater caring for one another. Specifically, depending on the maturity of the pair and the children's needs the moment, the therapist uses such techniques as *empowering* the children; *linking* their perspectives; and *enabling* them to see a shared point of view, which typically means helping the partners see what is best for their relationship. These three techniques will be described in detail in the sections that follow.

EMPOWERING

The therapist can empower children who tend to interact impulsively with others by helping them to identify and articulate their own beliefs, desires, goals, and feelings. That is, the therapist helps the children to identify personal points of view (rather than simply to engage in unreflective action) and to see how their different perspectives (i.e., desires, interests, and beliefs) affect their own behaviors. By helping the children see how

their desires relate to their actions or lack of action, therapists help children to gain a sense of efficacy and control and learn to take responsibility for their actions.

How does empowering look in practice? When a therapist sees a power imbalance—such as one child always bossing the other—he or she will call the child's attention to this pattern. Therapists may want to allow time for the pair to modify their own relationship if the imbalance presents no immediate risks, but the therapist must be sure to communicate his or her perspective on their behavior. As the children may not hold their own perspective clearly, the therapist must carefully select times to share ideas about how each child may have experienced an interaction. In sum, the therapist's reflections on the children's individual needs, interests, and beliefs empowers them to gain a more differentiated view of their own points of view, making possible the next level of maturity in interactions. On one hard, a therapist should avoid critiquing and directing the children's every interaction; on the other, he or she must avoid reinforcing ineffective or abusive behavior by saying nothing.

LINKING

Once a child is able to understand that he or she has unique wishes and interests, the therapist encourages the child to understand the partner's perspective and then links each child's perspective or behavior to the other's. The therapist can do this by helping Partner A tell Partner B how Partner A is feeling, what made Partner A feel that way, and what Partner A would like to happen next time. Sometimes therapist may need to articulate this for the pair; for example, by saying, "Tom's feelings seem to be hurt because you haven't allowed him to select a game in several weeks. I think he would like to choose the game today. Is that right Tom?" Teaching and modeling these assertive statements by describing feelings, identifying the problem, and suggesting concrete solutions helps the children communicate and negotiate more effectively on their own.

When linking, the therapist's primary focus is to help each child hear, acknowledge, and respect the other's opinions, desires, experiences, and feelings. The therapist links the children's perspectives by helping them see conflict as a shared concern that they must work out together in a way that satisfies them both. The therapist facilitates cooperation, therefore, by helping the partners with reciprocal negotiating, problem solving, and sharing.

In times of conflict, the therapist will help the partners by breaking down the steps of problem solving and encouraging the children to follow them. He or she will model the process of identifying or agreeing on a goal, then help the children generate various possible ways of resolving the conflict. Lastly, the therapist helps them choose and implement a strategy both agree on. When successful, the therapist will praise the children's work, describe how both got their own needs met in the situation, and encourage them to think about other ways to cooperate.

ENABLING

Enabling is the third structuring tool available to the pair therapist, and it is used when children cooperate well but still maintain self-serving goals, not seeing what is best for their relationship with their peer over time. Although successful coordination of one's needs and wants with the needs and wants of a peer is an important skill—one that is certainly a considerable advancement over fight or flight strategies—lasting relationships require the capacity to consider the impact of present interactions on the relationship over the long run. Enabling entails helping children see that their relationship will strengthen if they balance their *individual interests* with the *needs of the relationship* over time. This is a particularly difficult task because, in many societies, it is a skill that is neither taught, practiced, nor modeled regularly. Furthermore, it is not a skill that normally develops prior to early adolescence. Nevertheless, the capacity to collaborate, to establish a "we" perspective in a close relationship based on mutuality and shared reflection, is the keystone for developing close friendships and romantic relationships.

Pair therapists can enable this mutuality in relationships by helping the children gain perspective on their friendship and think about their actions in terms of the consequences for the friendship itself, not just in terms of each child's imme-

diate needs. Therapists help the children review their shared history, remind them how they have settled similar past disputes, and help them think about the ramifications of their different ways of settling conflict. The pair therapist also helps them recognize times when they have been able to collaborate, coming up with ideas and interests benefiting them both. The therapist's primary focus is to enable the children to see the importance of their relationship and to foster their ability to care for, support, and respect the other person.

A Typical Pair Therapy Session in a Day Treatment School

What does pair therapy look like? The following is a brief description of a typical pair therapy session, or the activities of a pair therapist from the time he meets the children until they return to class.

Each week the pair therapist shows up at the door of either Kenny or Carl's classroom and goes with that child to get his partner. The three walk to the therapy room. During the entire 50-minute class period this day, the pair of students will work and play together in the therapy room.

The room is familiar and all three take their usual seats, corner, or space. The pair therapist waits a short while for spontaneous conversation before touching base with the kids, briefly asking how they are. He does this to discover if there are any pressing issues that either boy might need to address before beginning the work, whether the work will be talking, playing, planning, or disagreeing. On this particular day, the boys do not say anything; they would rather get right to their favorite activity, Monopoly.

As they prepare to play the game, the pair therapist shares his thoughts about how the last session went. During the previous session, Kenny caught Carl cheating at Monopoly, but Kenny said nothing about it to Carl. This is consistent with a pattern of interacting that has emerged between the two, so the pair therapist encourages the boys to talk about it. He wants the boys to express their thoughts on this issue before they play Monopoly again so that they can both recognize the power imbalance they perpetuate. He hopes that empowering them to articulate their perspectives will lead to more honest game play. After the pair therapist reviews what happened the last time they played and the boys discuss what the cheating means to them, the boys resume their activity.

The boys play for much of the hour, talking throughout, but the last 5 or 10 minutes are spent reviewing how they played with each other. The boys evaluate themselves and their day's work. They talk, for example, about the fact that neither boy cheated, and they discuss whether this is a better way to play. The pair therapist identifies moments of conflict and compliments the boys on how they handled the situations. He asks them if they would do anything differently next time; they say no, they liked the way they played together today.

Before returning to their classrooms, the boys and the pair therapist talk about what they might do next week. Kenny says he wants to throw a football outside. Carl says he has one he can bring, and the pair therapist encourages Kenny to remind Carl to bring it the following week. He also reminds the boys that, since there are only 2 months left in the school year, they might consider what they might like to do or accomplish in pair therapy during that time. He also points out some progress they have made so far and helps Kenny and Carl describe the changes they have observed in their relationship and think about ways each might be a better friend to the other. This does not take long because the kids do not contribute much. Nonetheless this ritual is an important wrap-up for the day, reminding them of the purpose of their time together and setting the tone for the next meeting. All three leave, and the pair therapist walks the boys back to their classes.

Practical Considerations

Various institutional factors—including scheduling issues, billing, and the availability of facilities and equipment—have an impact on pair therapy. Pair work, when delivered in treatment-oriented institutions (i.e., day and residential treatment

centers) is usually complemented by other services, such as individual and group psychotherapy, speech and language therapy, and academic remediation (McCullough, Selman, & Wilkens, 1997). The scheduling of pair therapy in those settings, therefore, must be coordinated with that of other services. Residential treatment settings may offer great flexibility in scheduling, given the availability of after-school and evening hours. Games and other activities for use in pair therapy are usually readily available in these clinical settings, since the settings are likely to be used for a variety of purposes.

It is essential in public school contexts for the principal and teachers to understand and fully support the goals of a pair therapy program and for parents to give informed consent for their child's participation in pair therapy. Principals generally welcome pair therapy because of the negative impact of severe interpersonal problems on academic achievement and school climate and because few, if any, other services are available to deal with these problems. Nevertheless, resources for pair therapy (i.e., time, space, and equipment) may be limited. Scheduling must be carefully and sensitively coordinated with teachers so that the coming and going of children from the classroom is not overly disruptive to others or stigmatizing for the children receiving services.

Conclusion

Children and adolescents develop their capacity to engage in caring, intimate relationships through their involvement in peer relationships. Many troubled children and adolescents, however, never develop their potential to participate in close peer relationships and, instead, participate in exploitative and abusive relationships as victim, victimizer, or both. Sadly, these relational patterns often persist into adulthood, becoming a legacy for future generations. Pair therapy is based on the assumption that children—even those who are severely dysfunctional in their relationships with peers—can learn how to become friends, to trust and be trustworthy, and to take care of themselves while caring for others. When these lessons are learned, cycles of abuse, social isolation, and rejection can be broken.

Pair therapy, a relatively well-documented dyadic therapy, assumes that it is through corrective interpersonal experiences in peer relationships that troubled youth learn how to care for and get along with peers in healthful ways. This assumption, at the heart of the pair therapy approach, differentiates it most clearly from individual psychotherapy, where there is no peer with whom to practice relational skills (such as conflict resolution and experience sharing) or to build and maintain an ongoing relationship.

Managing conflicts and the feelings that they can engender is paramount in the relationship-building process in pair therapy, just as in any intense, long-term relationship. The pair therapist supports the participants in staying together and working through conflicts in increasingly mature ways. These experiences in pair therapy may contrast with what the participating children experience personally in other relationships or witness in the media where intimidation, aggression, fleeing, and abandonment are commonplace strategies for managing difficult feelings and accomplishing ends. If so, pair therapy offers troubled youths a critical alternative template for engaging in relationships that can help them begin to fulfill their deepest personal yearnings for both closeness with and secure independence from others.

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