A Child Psychotherapy Primer

Establishing and Maintaining a Relationship with the Child

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WHAT ARE SOME INITIAL MOVES YOU CAN MAKE TO START A RELATIONSHIP?

The general answer to this question is to act naturally with the child. Don't be condescending. As children we have all been put off by the neighbor or distant relative who said to us in a falsetto voice, "My, what a big boy you are!" or "Aren't you a pretty little girl!" Also to be avoided are the stock questions: "How old are you?" "What school do you go to?" "What grade are you in?" "What is your favorite subject?" "What do you want to be when you grow up?" "Do you have any brothers or sisters?" These are some of the approaches that do not help establish rapport with a child. What does help?

The first contact probably will be in the waiting room. You might approach the adult with the child and say, "Are you Mrs. [Smith]?" If she indicates yes, say, "Hello, I'm [Joe Dodds]." Turn to the child and say, "And you must be [Michael]. Come on [Michael], I want to show you the playroom." In a recent first encounter with an 8-year-old client, Scott, I had a parking sticker from the clinic office for the parent's car. I explained to Scott how it needed to be stuck on the window so they would not get a parking ticket and asked him if he would mind going out to put it on the inside of the rear window. Scott soon returned saying that the Scotch tape I had put on the sticker was on the wrong side for the sticker to show through the window, which caused laughter all around. This episode accomplished several things by way of establishing a beginning relationship between Scott and me. It was a real task that needed doing, and I let Scott know that I believed he was competent to do the job and independent enough to achieve it. It was a reasonable request for help that established the link between two people—"You have done something for me so you may expect that I shall try to do something for you." My error with the tape and laughing at myself gave the message to Scott that this doctor is human and he does not pretend to be infallible.

On the way to the playroom it would be natural to make small talk such as casually saying, "Have you been here before?" "You are probably wondering what it is like here." "I like that sweater you are

wearing." Or even a weather comment like "What do you think of all this snow?"

On entering the therapy room you might say, "Here is where we will be working and playing together." If you then stand around awkwardly, the child is likely to feel your discomfort, which will add to the child's own anxiety. Do something that feels natural, such as sitting on the floor or wandering over to pick up a ball or a piece of clay to fiddle with. This activity should not be the focus of your interest; rather the child should be. You will be modeling the combination of play and talk. You may wish to tell the child that he/she can look the room over and allow some time for exploration.

Within the opening minutes of the first session, I prefer to tell the child openly and simply what I know about him/her, what my understanding is of the presenting problem that brought the child to the clinic, and how we will work together. Here is an example of how it might go: "Jay, let me ask you, what is the reason your parents brought you here?" Seldom will children at this early stage reveal to the therapist, even if they know, the reasons they were brought to the clinic. Usually children will say, "I don't know", or give some peripheral reason. Continue with, "Well, let me tell you how I understand it; then you can tell me how you see it. Your mother has told me that she is very worried about your fighting so much at school and that you are upset sometimes about your father leaving home last year. Did you know she worried about that? She doesn't like you to be so unhappy, so she came here for some help. I told her that I couldn't make you stop fighting at school, but after we got to know each other, I would try to understand what was going on from your point of view and be of help to you if I could. But first we have to get to know each other, and that is what this room is set up for. I am always a little nervous when I first meet someone, so let's play today. Why don't you look around and see what you want to do?"

In the long run, I believe, it is easiest to let the child know immediately what you know about the reason for the referral. If you wait for the child to bring up the referral issue, it may never come up. Some nondirective therapists, such as existentialist Clark Moustakas, would argue that one should be truly nondirective, and that if the child does not introduce a topic, then he/she is not ready to deal with it. To spend so much time with a child waiting for him/ her to bring up a psychologically important topic produces much tension in the therapist and must influence the therapist's interaction with the child. I believe that telling the child straight out what you know clears the air and helps set the stage for open communication by modeling openness early in the relationship. Of course, the child does not have to

plunge right into a discussion of the problem if he/she is not ready to do so, which is the usual case, but at least the door has been unlocked.

One of the first techniques students in basic adult interviewing usually learn is to ask open rather than closed questions that can be answered by yes, no, or other single words. This is also a good technique in relating to children. For example, asking, "What do you like to do for fun with your friends?" has far greater potential for establishing continuing interaction than does "Do you have many friends?" or even "Who are your friends?" The temptation to ask yes-no questions is particularly great with children who are not very fluent in their initial dialogue—at least you get some response. The problem is that the conversation quickly takes on the tone of a grilling. It is probably best to stop asking questions entirely than to fall into this pattern. Of course, the advantage in working with a child in a playroom as compared to an adult in an interview room is that you do have materials on which you can focus your mutual attention; asking no questions at all is an alternative to asking closed questions when the child is not responding to open questions.

In some clinics the intake interview is with the entire family. In my experience, family intake opens up a great deal of material very quickly and is also valuable in learning about family feelings and dynamics. The family intake also affords an excellent way for the therapist to establish immediate rapport with the late-latency-age child or adolescent. Generally, the parents have one worker and the identified child client another. If the family session is followed by an individual session where you will be alone with the child for the first time, a good entree to forming an alliance with the child is to start by commenting on the vibrations you picked up in the family session. You might say something like "Boy, that was a heavy session! It felt like the whole blame was being dumped on you." or "Wow! I was sure uncomfortable in there; there sure was a lot of anger flying around." In my experience such comments give the child an immediate sense of alliance with the therapist. The child thinks, "Here is someone who knows what it is like for me in my family."

HOW DO YOU GET ON THE CHILD'S LEVEL?

To be in the child therapy business, it helps to be able to regress in one's level of play. If you feel terribly awkward and uncomfortable sitting on the floor playing with dolls in a dollhouse or engaging in

silly rhyming games with a child, then you should think twice about becoming a child therapist. For the effective child therapist the regression is not total; although the therapist interacts at the child's level, one corner of the therapist's mind is aware of the regression, monitoring what is transpiring, and speculating about the meaning the play has for the child.

Being loose and a bit goofy in the playroom could be helpful to both inhibited and impulse-ridden children. For the inhibited, too-grown-up child, the regressive behavior of the therapist can model for the child that it is safe to act in an immature way, that one does not become permanently regressed but can act older when the play time is over. For the impulsive child, the therapist's regressive behavior can model controlled regression, that is, acting out infantile impulses without losing control. Such play with this type of child often progresses with the therapist continually reminding the child of the limits on wild behavior.

A practical suggestion as to how to get on the child's level is to literally, physically, get on the child's eye level.

This means dressing in clothes that allow comfortable floor sitting. At the very least, the therapist should sit on a child-size chair. When the therapist is on the child's physical level, then he/she can follow and amplify the child's lead in play. For example, if the child makes two dolls fight, the therapist can provide sound effects; if the mother doll spanks the child doll, the therapist can cry for the child; if the child squashes a ball of clay, the therapist can squash a ball even more vigorously.

HOW DIRECTIVE SHOULD YOU BE?

The answer to this question depends entirely on the therapist's theoretical model. The existential therapist assumes that regenerative forces lie predominantly within the child and that, given the proper climate, the child will achieve a more complex and adaptive level of dealing with stresses. Therefore, the existential therapist would be nondirective. If the goal is to teach the child new skills or to modify the child's behavior in some way, then the behavior therapist would, of course, be quite directive. Somewhere in between these two points the directiveness dimension would be the psychoanalytically oriented psychotherapist whose objective is to focus on and bring to consciousness material from the

unconscious, so as to allow resolution of neurotic conflicts. In the psychoanalytic sessions the child is allowed free play with flexible materials, but the therapist picks up on symbolically significant play and play productions. The therapist encourages further elaboration of the play, probes as to its meaning for the child, and perhaps interprets to the child the significance of what is revealed through the play.

Also, between the two extremes of directive-nondirective are models that allow for a shift during any one session in the degree of directivenes. These models employ periodic teaching of the child within a generally nondirective framework. Examples of such teaching are helping the child achieve cognitive comprehension of conflicting emotions (Harter 1977) or teaching an isolated child how he/she turns off other children by pointing out how he/she annoys the therapist. It is in the spirit of the therapist accepting what the child has to offer that the child, one hopes, will accept what the therapist offers from time to time.

We know enough about nonverbal, subtle reinforcement in a two-person system to know that truly nondirective therapy is impossible. What the successful nondirective child therapist should be doing is behaving in ways that reinforce a child's self-expression. Reinforcing behaviors of the therapist could include giving attention, smiling, joining in the play by following the child's lead, and so on. The child may express him/herself by making choices, by creating products (tangible and fantasy), and by examining his/her behavior and desires. By paying close attention to the child's explorations and products the therapist also conveys the message to the child that he/she highly values the child as a unique individual. The nondirective therapist becomes directive, however, when the child crosses or threatens to cross the limits of the therapy situation by harming self, therapist, or room.

In reality few, if any, therapists are entirely consistent in the degree of control or direction they assume during any one session or from session to session. Whatever the therapist's theoretical orientation, the skilled worker responds to the child's needs, moods, and behavior and to his/her own needs and moods in a flexible way to maintain rapport and balance in their working relationship. Allowing the child some latitude of behavior and a good measure of control of the therapy situation helps maintain the child's interest and motivation for continuing therapy work.

HOW DO YOU DEAL WITH QUESTIONS THE CHILD ASKS ABOUT YOUR PERSONAL LIFE?

In tackling this question it is helpful to distinguish between two variables that are not necessarily related: degree of openness of the therapist within the therapy relationship and degree of revelation to the client of the therapist's life outside the therapy relationship. For an excellent discussion of this issue, see Jourard (1971). These two variables are represented graphically in Figure 5–1. The open-closed variable has to do with how real, how emotionally responsive the therapist is with the child, how much the therapist shares his/her reactions in the relationship with the child. The privacy variable is just what the label says: how much of the therapist's life outside the therapy relationship is revealed to the child? In Figure 5–1, therapist X is open in expressing feelings to the client about their relationship. Much of the time she reveals to the client when she is happy, angry, excited, or sad about the client's behavior, ideas, feelings, and experiences and about the therapy relationship. She also reveals a great deal of her private life—her family and other relationships and her experiences outside the therapy room. Therapist Y is even more open in her relationship with her client but reveals very little about her life outside of the therapy relationship. You may place yourself in any position on this graph to represent how open you choose to be in your relationship with your client and about your life outside the therapy relationship. Your position on the privacy dimension may be anywhere from telling the child nothing about your private life, to simply answering questions but not elaborating, to sharing practically everything and introducing private material into the session even when the child has not asked about it.

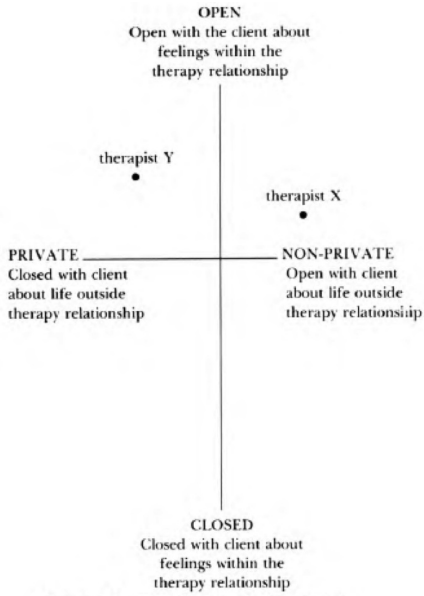

Figure 5–1. Two dimensions of openness: therapist's private life and therapist's relationship with the client.

Whatever you decide about how much of your personal life you will disclose to the child, most children in therapy become curious and sooner or later ask about their therapist's life outside the therapy hour. "Are you married?" "Do you have any children?" "What is your house like?" "Do you have any pets?" "Do you see other children here?" These questions, of course, grow from the child's need to figure out the relationship between him/herself and the therapist. Jealousy is often an issue. The child might think, "Am I so important as to be the only thing of importance in your life?

How might you respond to a child's questions about your children, for example, if you are open about yourself in therapy but closed in revealing information about your private life? Here are some possibilities: "Why do you ask?" "I'm flattered you are interested in me enough to ask." "You must be very curious about my life outside this room." If the child persists in wanting to know the answer to the question, you might say something like: "I have a rule against talking about myself , what I do, outside of

this hour. What is the most important thing is you and me right here, right now in this room." If the child responds with disappointment or anger you might say, "I feel bad [said only if you really feel bad] about not being able to tell you because I know you really want to know, and I don't like to disappoint you."

It is often informative to find out what the child's fantasies about you are. They could reveal something about the child's wishes and fears regarding the relationship with you. Even if you do answer the child's questions, say, about whether you have children, you might say, "I will tell you, but first let's see what you think; do you think I have children?" If, however, you have taken the position that you will not tell the child whether you have children or not, then it is probably better not to engage in this dialogue, because it would be too provocative to the child and too withholding on your part.

You may wish to pursue with the child his/her feelings that led to the question and about the frustration of receiving no answer. In any case, if you are open in your relationship, you say how you feel about the child's asking the personal question and how you feel about being pressed for an answer. In other words, you may be very open about your emotional reactions and feelings in that situation but still not reveal anything about your private life.

HOW DO YOU GET TO A FEELING LEVEL IN THE RELATIONSHIP?

Implied in this question is an unstated value that working on the feeling level with a child in therapy is desirable. I hold that value. There is nothing sacrosanct about dealing with feelings per se, but most of the children with whom we use play therapy techniques come to us with difficulties in the emotional-behavioral sphere. They may also have cognitive deficits, but if these are the primary reason for referral, reeducational techniques are generally used to help the child. The kinds of emotional difficulties children who are referred to child therapists often have are too much guilt, too much anger, too much sadness, and conflicts between incompatible emotions. The psychodymic theories hold that these problems may result in maladaptive behavior and that one way to change behavior is to have the children learn to identify their feelings cognitively and change them or learn to deal with them in more adaptive ways. This is not to imply that cognitive and educational techniques cannot be used to help understand and change behavior but rather that the emphasis in this kind of therapy is on the emotions.

The therapist has two general approaches to getting on a feeling level with children: modeling feelings that the therapist is having or has had and labeling and encouraging the expression of the child's feelings. The first step for the therapist who wishes to model the expression of feelings is to identify and monitor his/her own feelings as well as those of the child. Self-disclosure begets self-disclosure, as Sidney Jourad's (1971) research has demonstrated. The therapist can then model the expression of feelings by making comments such as, "Whoopee! I am glad when I win a game." "I don't like to lose, I feel stupid [or angry]." Or "I am getting bored with this game." Clearly the therapist does not keep a running commentary that reflects the continual parade of feelings being experienced, but he/she selects those feelings that are strongest or, more importantly, those that parallel the feelings the child might be having difficulty admitting or coping with.

Another way the therapist may use his/her own feelings to help the child recognize feelings is to reflect how the therapist feels (or has felt) in a situation similar to that being experienced or described by the child. For example, "I get really upset with myself when I can't hit the target." "That is interesting that you were not upset when you got the F's on your report card, because I used to get terribly sad when I got poor grades. I thought I was really stupid." Or "I used to get furious with my mother when she made me come in from playing to watch my baby brother." The therapist, however, must be truthful in these statements or the child will sense their nongenuine nature. Or as the child describes an event in his/her life the therapist might say, "That makes me feel just to hear about it." With this approach the therapist and child do not get into a conflict around denied feelings; the child can either agree with or ignore the statement, since how the therapist would feel is not debatable by the child. Possibly a responsive chord will be struck in the child like, "Hey, this old person is human; he [she] really understands me." Even if the reaction of the therapist does not strike a similar emotional chord in the child, the child might at least feel, "Well, he [she] is wrong but is trying to understand me anyhow. I must be worth trying for."

In addition to modeling the verbal expression of feeling, the therapist can label the child's feelings for him/her. It is easy, however, to overdo this, and I have had children tell me to shut up about feelings. One of my students was working with a child who was particularly closed to his feelings. Whenever the therapist tried to talk about feelings or interpersonal events, the child would say something like "Shut up, you're wasting our time. Don't talk, play!" Occasional casual comments might help the child learn to label; e.g., "You seem mad today," or "Let's celebrate your happy feeling." Questions can be used, such as

"I should imagine you would be jealous of your sister. Are you?"

Cognitive devices, like having children draw conflicting feelings in one person, can be very helpful. See S. Harter (1977, 1982) for an excellent discussion of this device and the rationale behind it. With younger children I have occasionally used a series of faces drawn to depict different emotions, asking the child to point to the one most nearly like his/her feeling.

To move beyond simply becoming aware of, labeling, and/or expressing feelings the therapist, through discussion or simple illustration, can help the child learn (a) acceptance of his/her feelings, (b) reasons underlying the feelings, and (c) ways to cope with emotions that result in more satisfactory interpersonal relationships for the child. The level of these discussions must be geared to the level of the child's language development, cognitive development, and tolerance for dealing with generally upsetting feelings. Beginning therapists frequently hold too high expectations for these kinds of conversations with child clients, tending to want the child therapy to be a miniature form of adult psychotherapy. This verbal level of emotional work with children is often slow and frequently impossible.

As a rule, it is generally best to stick with the child's metaphor. That is, if the child is projecting a current family conflict and his/her own feelings into a doll play scene, the therapist does not explicitly relate the play scenario to the child's life at home; rather, the therapist encourages the child to develop the play as a means of expressing feelings, conflicts, and attitudes. In this way the child will bring feelings into consciousness only to the extent that he/she is able to tolerate owning these feelings.

WHEN AND HOW DO YOU START INTERPRETING TO THE CHILD?

We need first to define interpreting, then see which theoretical orientations do and do not call for interpreting, and finally, explore some techniques for interpreting.

In psychotherapy, interpreting means the therapist brings into the client's awareness feelings, attitudes, and relationships between events in the client's life of which he/ she had been unaware. The levels of interpreting might be described as (a) identifying and labeling feelings in the client, (b) identifying sources of feelings, and (c) connecting past events in the client's life with current feelings,

thoughts, and behaviors.

The child therapist working within the behavioral model may not interpret at all but rather work on changing overt behaviors. He/she might identify thoughts and feelings (responses) and interpret to the child their source (stimulus) if the thoughts or feelings were targeted for change. If the behavior therapist connected past events in the child's life with current feelings, thoughts, and behaviors, it would be called establishing a learning history.

The existential therapist, being nondirective, would not interpret at all but would provide a safe, accepting environment and wait for the child to experience repressed thoughts, feelings, and connections whenever the child could comfortably tolerate awareness of them.

Both the cognitive therapist and the psychodynamic therapist, for all their differences, would probably interpret at all three levels. Both would assume that the purpose of bringing thoughts and feelings into awareness is to help the child gain control and deal more adaptively with them. That this assumption has been challenged for lack of evidence has not stopped the cognitive or psychodynamic therapist from interpreting.

Preadolescent children often do not have concepts to understand psychodynamic interpretations such as unconscious motives, why they are a threat, and how defenses operate to keep them out of awareness (Harter 1982). If interpretations are made to a child, it is difficult to know whether they hit the mark, that is, whether they are in fact about material in the child's unconscious and whether the child is now aware of that material. Further, it is not known if bringing material to the child's consciousness makes any difference in the child's feelings and attitudes, since the child may lack the conceptual and verbal ability to express any changes to the therapist. Often the only indication of the therapist's accuracy in making an interpretation is a change in the child's behavior.

When in the course of play therapy do you start interpreting? If the model you are using calls for interpreting to the child, then you do so whenever you know what you are talking about and the child is able to "hear" the interpretation. Probably your relationship with the child will have gone on long enough for you to have become well acquainted with each other, first, so that you know the child well enough that you have evidence for the validity of the interpretations you make to the child, and second,

so that the child knows and trusts you well enough that he/she may pay some attention to what you are saying. Interpretations would be given sparingly, since you are unlikely to come up with 15 valid interpretations in a session, and even if you did, the child would probably think you were weird with all your talk. Beginning therapists often worry about giving the wrong interpretation. In my opinion a wrong interpretation offered in a speculative manner to the child will not do any harm because the child will not accept what does not fit. This is especially true if the interpretation is made in an indirect manner, as discussed below.

How do you make interpretations to a child? Unless the child is in his/her teens and is really verbal, it is doubtful if verbal modality can be used effectively to make interpretations to the child. The techniques of interpreting to a child will vary according to the child's conceptual capacities and psychological readiness to hear interpretations. Susan Harter (1982) has beautifully described four levels of techniques of interpreting, from the least direct to the most direct. The *first level* she describes is interpreting through a doll play scenario by making an interpretation about a doll that resembles the child in some respect. For example, you might say, "This boy [doll] is shoplifting because he is angry at his father for leaving the family." The *second level* is to make an interpretation about a doll, as in level one, then to make a link between the doll character and the child: "I wonder if you feel like this boy sometimes." The *third level* is to make an indirect interpretation by discussing a "friend" who is like your client. You might say to your 9-year-old, red-haired client, "I have this friend who is nine years old and has red hair who, whenever he gets really angry at his father, goes out and steals something." Though the technique is transparent to the child, it does give the child a bit of distance or a chance to say, "Well, I'm not like *that* friend." Finally, the *fourth level* is direct verbal interpretation to the child. For a more detailed explanation and rationale of these levels I urge you to read this excellent work of Harter's (1982).