A Child Psychotherapy Primer

General Considerations

Josiah B. Dodds PhD

GENERAL CONSIDERATIONS

Josiah B. Dodds Ph.D.

e-Book 2016 International Psychotherapy Institute

From *A Child Psychotherapy Primer* Josiah B. Dodds Ph.D.

Table of Contents

GENERAL CONSIDERATIONS

WHAT IS CHILD PSYCHOTHERAPY?

Child psychotherapy is the process whereby a child is helped in a relationship with a psychotherapist to resolve emotional, behavioral, or interpersonal problems. The process is designed to change the child in some way, either to ease internal pain, change undesirable behavior, or improve relationships between the child and other people who are important in the child's life. Change in the child is effected by a variety of methods. Commonly used methods are a range of behavior modification techniques, many forms of play therapy, family therapy of different models, directive counseling, and cognitive therapies. There are other less direct methods of helping a child change, such as parent counseling and manipulation of the child's environment, but they are not generally considered to be child psychotherapy. Issues involved in these methods will not be considered in this book. Certainly many other relationships and experiences the child has can be "therapeutic," that is, can ease intrapsychic pain, change behavior, and alter the nature of interpersonal relationships. So what differentiates psychotherapy? All methods of child psychotherapy require the establishment of a therapeutic relationship between the child and a mental health professional. This relationship differs from all others.

WHAT IS THE NATURE OF THE CHILD-THERAPIST RELATIONSHIP IN PSYCHOTHERAPY?

The relationship between the child and adult in psychotherapy is different from other relationships the child has. It is easier to discuss what the therapy relationship is not than what it is. It is unlike the child-parent, the child-playmate, the child-teacher, the child-big brother/sister, and the child-older-relative relationships. There are, however, some elements of each of these relationships in the child-therapist relationship. Not only can the child transfer portions of these relationships into the therapy relationship but the therapist also acts like these people in some ways. For example, to the degree that the therapist sets limits to insure the child's and therapist's safety, he/she is like a parent. To the degree that he/she interacts with the child in games and free play, the therapist is like a playmate. To

the degree that the therapist conveys support and positive feelings to a child with whom the therapist has a special relationship, he/she is like an older relative.

Just as the child-therapist relationship is not devoid of elements that characterize other relationships of the child, these other relationships are not devoid of the elements characterizing the child-therapist relationship. What characterizes the child-therapist relationship grows out of the therapist's attitude and behavior with the child. The therapist accepts most of the child's behavior and all of the child's thoughts and feelings with a nonjudgmental, supportive attitude. The therapist places a high positive value on the child's right to these thoughts and feelings. The time in the interaction between therapist and child is spent focusing on the child's behavior, perceptions, fantasies, and feelings rather than on the therapist's, with the goal of helping the child to achieve more mature and adaptive ways of adjusting to life's stresses. Underlying the child-therapist relationship is a professional contract between a helper and a helpee that differentiates it from family relationships, which are maintained primarily on love and/or obligation, and that differentiates it from relationships with playmates, which are based on the mutual exchange of friendship. A professional contract also underlies the teacher-child relationship, but the teacher is generally expected to impart knowledge and skills in the cognitive realm directly to the child and to be less focused on the child's feelings and fantasies.

WHAT IS THE DIFFERENCE BETWEEN CHILD PSYCHOTHERAPY AND PLAY THERAPY?

Play therapy is one method of psychotherapy that may be used in helping a child resolve problems. Play therapy is more of a technique than a cohesive theory. Some workers in the field believe that any free play with an adult will be beneficial for the child; that is, they believe that given an unstructured environment with an accepting adult the child will inevitably work out his/her problems. The accepting adult, a play therapist, would not necessarily need to be a trained child psychotherapist.

Others in the field, including myself, do not have as much faith in the hypothesis that unrestricted play alone is always sufficient for resolving the child's problems; they plan ways to intervene in helping to solve the problems. Play may be one of the methods used. It would be instituted with a rationale that would fit the clinician's conceptualization of the child's problem and the means of intervention.

The psychotherapist's conceptualization of the child's problem greatly influences the course of therapy even if it is "nondirective." The influence is through the responses the psychotherapist makes to the child's play, fantasy, and talk. The responses grow out of the psychotherapist's conception of the child's problems and what he/she thinks will help resolve the problems. Even the nondirective psychotherapist will convey these conceptualizations by selective attention to the child's behavior.

HOW DO CHILD PSYCHOTHERAPY THEORIES DIFFER?

Child psychotherapy theories can differ greatly from one therapist to the next on several dimensions. The beginning student of child psychotherapy might find the following dimensions useful when comparing the various theories and techniques of child psychotherapy.

1. The child may be viewed as motivated from within (self-actualizer) or from without (reacting organism) or some balance of these two.

2. Particular therapeutic schools might call for special rooms, equipment, and materials.

3. The therapist may be more or less active in directing the child-therapist interaction.

4. The therapist may actively teach the child new skills, behaviors, and attitudes or let the child discover during the course of therapy new ways of behaving and new self-understandings.

5. The therapist may use his/her own feelings and emotional reactions during the session or attempt to remain emotionally neutral.

6. The therapist might encourage, discourage, or ignore transference phenomena in the child.

Whatever position along these dimensions any one child psychotherapist takes, they would all agree that the child's play is a means of communicating and that the therapy room equipment and materials are to facilitate that play communication.

WHAT IS A PLAY SESSION?

In layman's usage, a play session means any time period in which any play is occurring. It could be by one or more persons, by children or adults, with any materials and for any length of time. The use of

the term in the mental health professions, however, has a more specific meaning. Usually the following conditions are present when the term play session is used in mental health circles:

1. At least one child, who is in the client role, and one adult, who is trained in some mental health profession, are present.

2. A place is designated as the place of play, usually a playroom or a designated part of a room such as an office.

3. A specified period of time, generally between 30 and 90 min, is set aside for the play.

4. Materials are present that encourage expressive behavior and imaginative activity of the child.

5. The focus of the adult's attention is primarily on the child's activities, thoughts and feelings.

6. A therapeutic relationship between the adult and the child is established.

WHEN IS THE PLAY METHOD APPROPRIATE?

The play method is most helpful for children with internal problems such as fears, anxieties, guilt, poor self-image, feeling of being deserted, jealousy, grief, and anger. The method is appropriate whenever the child's communication with the therapist can be facilitated through the medium of play. Anyone who has worked with children, especially young children, knows how difficult it can be for a child to talk about feelings and about the kinds of complex human interaction problems that often bring the child to the clinic. The young child's language and cognitive constructs are not sufficiently developed to express these concepts verbally. Developmentally, the child first expresses feelings and desires most easily through action, then later through fantasy, and finally through language (Santostefano 1971). If the clinician and child are in a setting that has play materials, the child can find a balance of expression through action, fantasy, and language. The reflective child will shift the modality of expression, or combination or modalities, from moment to moment. The playroom facilitates this motility of expressive means.

The older child's language and cognitive concepts may be sufficient for expression of feelings and interpersonal events, but the child may be too unpracticed or too uncomfortable to discuss these matters. For example, children often are not at ease sitting and talking face-to-face with an adult, especially a

strange adult in an unfamiliar setting. In such cases focus on play materials and activities can place a comfortable barrier between the child and adult, thus helping the child avoid eye-to-eye, have-to-talk interaction until the child is ready.

AT WHAT AGES ARE PLAY TECHNIQUES APPROPRIATE?

Play techniques are generally used with children between 3 and 12 years of age, but there are exceptions either way at both ends of this range. Some 2-year-olds might profit from play therapy, just as some adults might. Then again, play may not be the most appropriate means of interacting with some 11-year-old children. As discussed above, play techniques are appropriate at any age at which they will facilitate or help regulate communication. One 9-year-old boy, coming into the playroom for the first time, remarked, "Are those dolls? Do I have to play with *dolls?*" "Not if you don't want to," I replied. After an interval so short it should have been embarrassing to him, the boy was busily engaged in doll play. Another boy, aged 12 and highly verbal, with whom I had worked for a year in the playroom, stopped one day at the door of an adult interview room and announced that he was ready to use the grown-up room to talk. He did and never returned to the playroom.

Youngsters in the 12- and 13-year age group present a dilemma. They may feel insulted by being taken into a playroom, but they may feel extremely uncomfortable sitting in an adult interview room face-to-face with a strange adult. Here is a way that I have found useful to handle this dilemma. At the first session you might show the youngster the playroom *and* an adult consultation room and ask him/her which room he/she would feel most comfortable using. In order to remove social pressure you might say, while showing the child the rooms, "Some kids, prefer to use this room and some prefer the other room. It doesn't matter to me—we can use whichever you prefer. Also, we can change later if you wish." In any case, I will always have available in the adult consulting room and within reach of both of us some clay, a deck of cards, paper and colored felt-tip pens, and perhaps a game of checkers. You and the child might pick up some clay or the cards to fiddle with while you talk. What this does is leave the option open for the child to do what he/she is most comfortable doing.

In general, given the opportunity, children will answer the question of appropriateness of using play materials themselves. If they are in a room with some materials, they will use them or not as they feel

comfortable. The answer to the question of when and at what age the play technique is appropriate is thus: If the child and the clinician can and wish to use play material to facilitate and ease their communication, then it is appropriate.

WHEN IS THE PLAY METHOD NOT APPROPRIATE?

Many children are brought to the mental health professional with problems that might be more effectively helped through techniques other than play. If the parent is unhappy with a child's behavior, such as not picking up his/her room, talking back, staying out past the time set for being home, and the like, then it is unreasonable to expect that play would necessarily change the child's behavior. Parent counseling or parent-child sessions would be a more direct means of tackling these kinds of problems. Similarly, if the primary complaint is a dysfunctional relationship with others, such as siblings, peers, or teachers, then intervention that involves both sides of the dyad is indicated.

You, as a child therapist, will be getting into a trap if you take on a child in play therapy acting as the agent of someone else, parent or teacher, who wants you to change the child's behavior. Perhaps as the child profits from play therapy by feeling better emotionally, by developing more mature and adaptive ways of dealing with internal and external stress, and by developing more positive self attitudes, the child's behavior with others will change for the better, but you cannot offer the parent or teacher a guarantee. To accept the child for therapy under these circumstances implies that you are accepting their goal for behavior change and therein lies the trap. The primary reason for using the play technique with a child is to help the child deal with internal problems, not to get him/her to change behavior that disturbs others.

Often children are brought to a mental health professional with a primary symptom such as bed-wetting, learning disability, or attention deficit and also with associated feelings of incompetence, shame, depression, and negative self-image. In these cases the approach could be twofold: (a) direct intervention on the symptom (e.g., bell and pad for bed wetting, remedial teaching for the learning disorder, or medication for the attention deficit) and (b) psychotherapy with play techniques to help the child change his/her concomitant negative feelings and attitudes.