A Child Psychotherapy Primer

Therapy Room and Materials

Josiah B. Dodds PhD

THERAPY ROOM AND MATERIALS

Josiah B. Dodds Ph.D.

e-Book 2016 International Psychotherapy Institute

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

Table of Contents

THERAPY ROOM AND MATERIALS

WHAT KIND OF ROOM IS BEST FOR THE USE OF PLAY TECHNIQUES?

Just about any space can be used for a therapy session. I have successfully conducted sessions in many different and difficult settings such as a 9-foot-by-9-foot office full of furniture plus two sit-in observers and a very active 6-year-old boy, in a small room in a trailer, and in a parochial school chapel (observed by Christ from the cross!). Since limits must be placed on the child by the therapist, particularly if the child needs help in learning to control his/her own impulses, the more childproof the room is the easier it is for both the therapist and the child. If the therapist uses an office with work papers on the desk, a blinking multiple-line telephone, potted plants on the windowsill, and fragile ornaments on the wall, an enormous amount of energy could be spent on limiting the child's behavior so as to protect those things. Few rooms are completely breakproof, but the therapist and child will both have a much easier time if the room is sturdy and does not contain easily damaged items.

If one were in a position to plan a therapy room in a new facility, the following features would make an ideal room. The room would be at least 8 feet by 12 feet to allow for some vigorous movement. The lights and windows would be unbreakable. If an observation glass is used, the microphone would be out of reach of the child and preferably not protruding into the room. Furniture would include a sturdy child-size table and two chairs plus a storage cabinet or shelves for standard toys and materials. A carpet on the floor adds comfort, but there should be bare tile floor at one end of the room for paint and water play. A sink with running water certainly adds convenience but is usually a luxury. If the walls are made of soft composition board, they will resist blows and knocks as well as being easily replaceable. It is helpful to have some storage space outside of the playroom for storing unused materials (so they do not clutter up the therapy room) and to safely keep projects or special materials for particular children.

WHAT MATERIALS ARE USEFUL FOR PLAY TECHNIQUES?

Consider these two principles in selecting therapy materials:

1. The materials allow for as much flexibility in their use as possible so that the child may have the optimum conditions for self-expression. Contrast a Slinky with a piece of clay: The former has a limited number of possibilities—bouncing as a yo-yo, going down stairs and becoming bent and useless—whereas the clay (oil-base clay that does not dry out) has a long life and an infinite number of possibilities. The clay does not so much have meaning in itself as it attracts meaning projected onto it. Toys that have movable (and therefore breakable) parts often draw the child into spending excessive therapy time manipulating a piece of machinery.

2. The materials offer the least possibility of harming the child, therapist, or room. If the limits set on the child's activity are those of not hurting the child, the therapist, or the room, then the more difficult it is to do this damage, the less likely the therapist and child will be spending time engaging in a struggle around limits. So one would avoid equipment such as darts with points (Velcro heads present few problems), punching bags that will swing up into the lights, hard balls that will break windows and heads, and guns that shoot missiles of some sort.

Each child therapist has a favorite set of play equipment; however, the beginner might consider the following:

1. Plastic materials: clay, sand, water, and fingerpaint. Play with water and fingerpaint is not recommended if the room is not equipped to cope easily with spillage.

2. Drawing materials: newsprint, crayons and pencils, possibly felt-tip pens, blackboard and chalk, tempera paints (again if adequate clean-up facilities are present).

3. Dolls in a simple dollhouse with simple, non-moving-part furniture. The standard doll family (mother, father, brother, sister, and baby) is used by some therapists, whereas others prefer to tailor the doll family constellation to reflect that in the child's household.

4. Hand puppets of people and/or animals.

5. Ball(s). (Child therapists the world over hail the invention of Nerf!)

6. Building blocks. If wood blocks are a problem, Styrofoam blocks are now available.

These additional items are found by many therapists to encourage self-expression and to facilitate

communication: games, from simple games of chance to cards and chess; a set of play telephones; punching bag; gun; dress-up clothes; toy soldiers; play dishes; cars and trucks.

THE CHILD INTO CERTAIN KINDS OF PLAY?

Yes, unless the therapist is operating from a *strictly* nondirective position. The degree of structure in introducing special materials for a given child may range from close to zero to a highly structured setup. An example of nonstructured use of special material would be placing a baby bottle and a baby doll on the playroom toy shelf for the child in whom one detects strong regressive and dependency pulls. The therapist's desire is to provide the material for projecting and acting out these themes. An example of a more structured use of special material would be providing a doll family constellation exactly matching the child's own family, then having the therapist act out the beginning of a scene that is salient for the child, such as a grandmother's death, and asking the child to continue playing out the scene.

The therapist often keeps in an out-of-the-way drawer or closet those materials to be pulled out for use with a particular child. I find plastic models particularly useful to facilitate interest and to promote give-and-take interaction between child and therapist. These are the rules I introduce to the child before starting work on the model:

1. "We must work on the model together."
2. "We leave the model here at the clinic until it is completed."
3. "You may take the model home to keep when it is assembled."

SHOULD THE CHILD BE ALLOWED TO BRING TOYS AND OTHER ITEMS FROM HOME INTO THE THERAPY ROOM?

Why not?

DOES USING DIFFERENT MATERIALS AT DIFFERENT SESSIONS OR CHANGING ROOMS CAUSE PROBLEMS?

I am repeatedly being surprised by children's sensitivity to changes within the therapy room or between rooms. Some children, of course, do not seem to give it a second thought, but many children

appear to be uncomfortable with changes. Frequently, the children seen in therapy have experienced many negative or unreliable behaviors from others. As a result of these experiences, their level of trust in the consistency of people is low. For these children, changes in the therapy room could be interpreted as evidence that the clinic is unstable, including the relationship with the therapist. I am unaware of any empirical data on this point, but it seems like a reasonable clinical hypothesis.

The child does not have the cognitive structures that an adult uses to obtain consistency. Adults know they are in the same country, state, and section of town and they know (generally) what changes will be coming up in their living quarters or jobs. The adult has the geographical and time concepts for interpreting these things that the child under 11 probably does not. So the child may react with major feelings to changes that would be minor to the adult.

The practical implications of the child's sensitivity to change are that the therapist should try very hard to keep the same therapy room and the same play equipment in that room. Consistency in these things can contribute to the child's sense of continuity and security in the relationship with the therapist. With many other therapists using the same playroom and materials, it is not always easy to keep consistency. It might be wise for the therapist to check out the room before the child arrives for the session.

The therapist should not overlook the possibility of using deliberately planned change as a therapeutic tool. Changes could be used to reach goals such as increasing the child's tolerance for inconsistency, moving the child to a different kind of relationship with the therapist, and adding special equipment for getting at special problems in a child.

CAN THERAPY BE CONDUCTED OUTDOORS?

If therapeutic interactions are occurring between therapist and child, it makes little difference where they occur. However, if you wish to go outside the therapy room to conduct therapy, you might think about your reason for doing so. Is it to avoid observation by the supervisor? Is it to accommodate the child who wishes to flee the therapy room (and therapy)? Is it to play more vigorous games than is possible in the playroom? Is it to get treats to eat? Is it to enjoy the companionship of a walk together? In

addition to understanding the reason(s) therapy moves outside, the beginning therapist might be aware of a few potential hazards.

1. Activities like catch, hide and seek, and Frisbee remove the therapist and child from easy verbal communication. Standing 20 feet apart and chasing balls makes it very difficult to explore verbally a child's feelings, fantasies, wishes, and attitudes, or to work out solutions to interpersonal problems. This may be exactly why the child wants to go outside and play ball.

2. Personal safety on city streets and parks is a concern. You should be particularly careful about exploring the risks involved in transporting the child in your own vehicle. Perhaps your clinic does not have insurance to cover a possible liability suit from an accident occurring under such circumstances. You may decide that the reasons for going out outweigh the risks, but at least you need to weigh them consciously.

3. Obtaining snacks at neighborhood stores is an easy thing to do. Is it therapeutic? If you wish to, can you say no to the child after snacks are bought the first time?

Going outside the therapy room is tempting and easy to do. The most important thing is to be very clear about how it facilitates progress toward the goals of therapy for each particular child.