Child Psychotherapy or Just Play?

Mary Boston

'What did you do at the clinic to-day?' Mother asks Tim. 'Nothing. Just play,' is the frustrating reply. Mother wonders if it is worth all the bother of taking him to his sessions, if that's all he does. He could do that at home. This rather familiar interchange (for 'clinic' substitute' school') illustrates some important points to bear in mind when undertaking therapy with children.

Children, especially younger ones, are usually brought to therapy, and therefore the parents' motivation has to be assessed as well as the child's and their co-operation sought. Otherwise they can consciously or unconsciously sabotage the therapy, or break it off prematurely. Parents may feel left out from what is going on between the therapist and the child, particularly if the child comes out with tell-tale signs of play like paint or water on clothes or plasticine under fingernails. Naturally parents do not want to entrust their child to someone who has not been properly vetted by them.

For these reasons, I never take on children for therapy without one or two preliminary interviews which include the parents — both parents, if at all possible. If the child is with a single parent, as so often happens nowadays, it is still worth making every effort to see the other parent if he or she has any contact at all with the child, especially if there is shared care or custody. Seeing the parents is also important if the child is seen in a school or residential setting, even though they are not involved in bringing him or her to therapy.

If there is uncertainty about whether the child needs help, it may be wise to see the parents on their own first, but on most occasions I find it helpful to see the whole family together. Preliminary family interviews have a number of advantages. They enable a more complete assessment to be made of the family dynamics and the part the referred child is playing in them, so that one can judge what kind of intervention would be best and most acceptable to the parents. It is useful if the child hears what the parents say about her, or him, and I have found that most children are interested to hear how they were as a baby and their parents' account of their history. They may not have heard it all before, and such an account is sometimes therapeutic in itself. You can also then use this information in work with the child without betraying confidentiality.

Mary Boston is a child psychotherapist, now retired, who trained and worked at the Tavistock Clinic in London, where she was a senior tutor in child psychotherapy. She has co-edited books on child psychotherapy and is currently an external examiner for the University of East London.

A further bonus of preliminary family interviews is that the parents can see the therapist in action with the child, which is far more effective than trying to explain to the parents alone what you will be doing. Of course it is important not to ignore the child while talking to the parents. I find it helpful if a small table with drawing materials and small toys can be strategically placed within the circle of parents, children and therapist. You can then watch and respond to the child while listening and talking to the parents. It is amazing how young children's play can sometimes link in with the parents' conversation. Daniel, aged five, referred for bedwetting, was very reluctant to go to bed. The parents were telling me how he would only go to sleep in his parents' bed and what a nuisance that was. I suggested that perhaps Daniel did not like the parents being together and I noticed Daniel pick up the father doll and hold it under the tap just as mother was describing how she woke up one night to find Daniel just about to pee over his father!

Another advantage of preliminary family interviews is that they keep the options open as to what further work may be required, whether to continue as a family, to see the child individually or to see the parents. If preliminary family interviews can be done with a co-worker, then separate work with both parties can be possible. If it is agreed that the child should come for individual work, it may be desirable for the child's therapist to see the parents again on their own, to give them a chance to say anything they have not felt able to say in front of the child, to ask further questions and to clarify the arrangements.

I find the space given to parents in this way is well worth while, as it enlists co-operation and regular attendance. Discretion however needs to be exercised in the case of older adolescents as to whether and how much their parents should be involved. In private practice, if parents are paying, my experience is that the parents do need to meet the therapist.

Is it just play that one does with the child? Of course play can in itself be therapeutic. Children who have been in hospital, for example, or who have suffered some traumatic experience, can be observed enacting the scene over and over again in play, and sometimes this helps them to come to terms with their experience. In psychoanalytic psychotherapy play is one of the methods of communication open to children — a vocabulary, as it were — since children, unlike adults, do not talk very readily about their problems. But play is only one of many ways of conveying thoughts and feelings to the therapist. Some children neither play nor talk, and non-verbal cues have to be picked up.

Caroline, for example, remained silent and motionless in her sessions with me. She had been fostered from babyhood, but was claimed back by her natural mother when she was nine. Training in the observation of small babies, which all child psychotherapists undertake, is very helpful in enabling the therapist to notice and respond to non-verbal cues. There are other children, particularly those with autistic features, who are unable to play at all and may be stuck in repetitive, stereotyped behaviour. Luckily most children are able to use the materials provided to help them to express their thoughts and feelings, both conscious and unconscious,

and the therapist's task is to try to understand them and to share this understanding with the child in words appropriate to his or her level of development.

The play material offered does not need to be elaborate, in fact I prefer to keep it fairly simple, with things which give scope for imagination: drawing and painting materials, plasticine, small figures of people and animals, cars, cups or beakers, scissors, string and paste. It is useful to have running water in the room, but not essential. Some people like to have a sand tray but I find it takes too long to clear up afterwards! Psychoanalytic psychotherapists usually provide an individual box of toys for each child to use in sessions. These can then be treated as the child wishes, even destroyed sometimes, without upsetting other children. A simple doll's house can be useful, and that of course does have to be shared with other patients, as does the water, sink and furniture.

The most important task of the child psychotherapist is to establish a suitable setting in which children can communicate their innermost feelings and anxieties. The provision always of the same room, the same toys and the same hour facilitates observation and offers a certain predictability and consistency which is helpful. A further very important ingredient of the total setting is the therapist's receptive frame of mind, open to whatever the child has to communicate. A neutral, non-directive attitude will permit and encourage children to express themselves freely. Hostile as well as friendly feelings can emerge within the firm limits of the room and setting. The provision of exclusive attention for the time of the session can prove a very containing experience for the child.

It is sometimes tempting to try more active ways of engaging a reluctant or uncooperative child, giving reassurance or intended helpful suggestions. I was especially inclined to do this with silent Caroline. But I came to realise that by her silent, uncooperative demeanour she was showing me just how she felt about being uprooted from the home she had known and put into a strange place with a strange mother. It turned out to be more helpful to stick with this situation, uncomfortable though it was for both of us, for this was the only way she could communicate how she felt without being disloyal to her mother. When I could bear, as her natural mother could not, being constantly rejected and treated as a stranger, Caroline eventually became able to draw and later to talk. Interestingly, she drew everything in duplicate, twin houses, twin prams and twin dolls. These seemed to represent her two mothers as well as her two selves.

In this example we can see that Caroline is transferring on to the therapist some of the feelings which belong to her outside life. In the therapy they can be thought about and she may be helped to come to terms with what has happened. By being receptive and neutral in attitude, such transference, the main tool of psychoanalytic therapy, is facilitated. It is particularly important to allow hostile or negative feelings to emerge in the transference and not to try to dispel them by reassurance or over-friendliness. This does not necessarily mean drawing attention to the child's anger. That may be like a red rag to a bull. It means the therapist has to tolerate being seen as threatening or unhelpful at times.

Otherwise the child may split off the negative feelings, have a lovely time with the therapist but vent the negative feelings at home. Naturally parents do not like that and may stop the therapy.

A moving example of the long-term importance of not giving too much reassurance is provided by Tom, a three-year-old, referred for violent and prolonged temper tantrums. His parents were at their wits' end. Tom could scream and kick for an hour or more and then suddenly 'snap out of it'. He was advanced in development and speaking well, and was able to use the play material to communicate vividly. After a cautious approach in his first session, he played with the tea set and pretended to drink. He explored the room and whispered a few questions to the therapist. This rather shy behaviour was in marked contrast to his bossiness to mother, as he kept returning to her in the waiting-room, demanding real drinks and ice-cream. He was reluctant to leave at the end, asserting he wanted to stay and play all day. His bossy behaviour quite quickly appeared in the therapy sessions and it soon became apparent that he was extremely intolerant of any frustration and of not getting his own way. His tyrannised family had resorted to bribery and he sometimes came triumphant with some new toy, saying 'I got it for screaming!' He got very angry with me because I did not bring him presents, nor did I replace toys he had deliberately destroyed. In his rage he would wreck the room, breaking and hurling toys. I felt it was important not to collude with this behaviour by bringing new play material. Apart from the fact that it would almost certainly have met a similar fate, I thought it essential to wait until he himself made a move to repair or mend. I tried to understand with him how he was feeling and to share with him the unbearable chaos and confusion in his mind which he regularly reproduced in the room.

One day he picked up a broken toy and hurled it across the room saying angrily, 'Why don't you throw it away?' I interpreted that he felt nothing could be done with broken things except to throw them away and replace them and that he was very frightened that that would be done to him (indeed his parents had talked of sending him away). This interpretation produced a dramatic change of mood. He came over and put his arms round me, saying 'I love you very much', and then told me about a 'poor little pussy' he had seen on a rubbish-heap. Tom was not easy to help, but sticking with his aggression and the projection of chaos and confusion did eventually bring things more under control and he became more manageable.

Tom was one of those children who communicate by action and this is typical of many deprived and traumatised children, as well as of adolescents. They communicate by their behaviour and you have to understand the message and bear the massive projections. The behaviour can take the form of aggression, as with Tom, or can be expressed in more subtle ways, such as erratic attendance or aloof indifference. In the series of deprived and abused children treated at the Tavistock Clinic in London, the therapists invariably found themselves made to feel useless, helpless and rejected — precisely the feelings these children needed to get rid of. It is important to be aware of feelings aroused in oneself — the counter-transference —

as this often gives clues about what is going on. Trust, especially by children who have in reality been let down, has to be earned in the therapy. If one can bear not being seen as helpful or good at the beginning but can understand the natural suspicion, eventually a more genuine trust can emerge.

Luckily there are children who express their anxieties and fantasies in play or drawing, sometimes dramatically, in a way which is easier to understand. Five-year-old Ben was brought because his parents were worried that he played with dolls and only with girls and liked to pretend he was a girl. They wanted him made into a 'proper boy'. But Ben was obviously anxious about this, expecting some sort of operation. He expressed this in his first session by snipping at the doll figures' clothes with the scissors, surreptitiously snipping under my skirt and by eventually cutting the man doll's trousers right off. While he was doing this he talked about his 'wiggy getting big' and I thought he was worried about a possible operation on that (he had in fact been circumcised at a rather late age). However, Ben corrected me, saying, as he patted his bottom, 'If I lose my bosoms I'll be a boy!' This illuminating remark made me realise that Ben was not just playing at being a girl; he really felt, unconsciously, that he was the mother with the breasts. Moreover he was quite confused between breasts and bottoms. His subsequent play further illustrated the theme. He took the little girl doll and put her with the daddy, saying it was a wedding. Then he put all the child dolls between his own legs, saying 'They are not born yet'. The doll family lived mostly inside the teapot where they were having a

'lovely picnic'. As time went on, Ben's great intolerance of frustration became more apparent. He would refuse to leave the lovely picnic he was having with me at the ends of sessions and sometimes had to be dragged from the room. I came to understand that one aspect of his feminine identification was his attempt to deny his separateness from mother and his inability to control the source of supplies.

Ben's parents were very keen to know how he was getting on, no doubt suspecting that I was allowing the feminine behaviour which they actively discouraged at home. The problem of confidentiality can be a tricky one. The parents naturally want some sort of report

and one has to steer a line between giving them some idea of progress (or lack of it) without betraying exactly what goes on in sessions. The initial interviews with the parents can prepare the way for this, but I find it best to be available to the parents at later points, if required. It is helpful if there is a colleague available to work with the parents, but this is often not possible.

Working with children is full of challenges; it can be hard work, even hazardous, and can present many technical problems. This makes it varied and interesting and often very rewarding. Younger children, in particular, can sometimes make rapid progress. A recently expanding field is work with mothers and babies together. Such early interventions can be a very important contribution to the prevention of subsequent difficulties.

Further Reading

Mary Boston and Rolene Szur (eds), *Psychotherapy with Severely Deprived Children*, Karnac Books, 1990 (reprint)

Beta Copley and Barbara Forryan, *Therapeutic Work with Children and Young People*, Robert Royce, 1987

Monica Lanyado and Ann Horne (eds), *The Handbook of Child and Adolescent Psychotherapy*, Routledge, 1999 (in press)

Lisa Miller, Margaret Rustin, Michael Rustin and Judy Shuttleworth (eds), *Closely Observed Infants*, Duckworth, 1989

Margaret Pustin, Maria Rhode, Alex Dubinsky and Helene Dubinsky (eds), *Psychotic States in Children*, Duckworth, 1997

Rolene Szur and Sheila Miller (eds), *Extending Horizons*, Karnac Books, 1991

Young People and Recreational Drugs

Aileen Milne

I have recently been exploring the idea that the use of drugs by young people is fulfilling, expressing some kind of need which is not presently being met within the structures of Western society. I am interested in what is happening psychologically and psychospiritually at the adolescent and young adult stages of development, and by the way young people are expressing themselves in society.

The London-based organisation Antidote, which calls for social reform in public

Aileen Milne is a counsellor who has worked with young people in various capacities for a number of years in the Gloucestershire area.