

PSYCHOTHERAPY WITH CHILDREN AND ADOLESCENTS



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American Handbook of Psychiatry

Psychotherapy With Children And Adolescents

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e-Book 2015 International Psychotherapy Institute

From *American Handbook of Psychiatry: Volume 5* edited by Silvano Arieti, Daniel X. Freedman, Jarl E. Dyrud

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Psychotherapy With Children And Adolescents

The first published reports of psychotherapeutic work with children—Itard's *The Wild Boy of Aveyron* (1962) and Freud's "Little Hans" (1955)—were separated in time by over a hundred years. Yet the outlines of the field they presaged are clearly discernible in the educational emphasis of the first case and the concern with intrapsychic conflict and its resolution in the second instance.

The so-called "wild boy" was eleven to twelve years old when he was captured. The child had no language, poor use of humanoid mobility, little capacity to relate, and, of course, poor habit training. He was at first diagnosed by Pinel as being hopelessly mentally defective. But Itard differed with this opinion and reasoned that the boy's condition was more likely to have been caused by the absence of social stimulation. (In recent years some have suggested that the boy may in fact have suffered from autism, a still unknown entity in Itard's time[Silberstein, 1962]) Be that as it may, the boy was named Victor—a charmingly optimistic gesture—and Itard spent considerable time trying to teach him how to adapt himself to the amenities of civilization. Itard's therapy was based on moral principles and employed techniques such as training, teaching, and the fostering of comfortable human relationships, which today we would identify with education. Through the teaching of proper conduct, language usage, and habit training, Itard

attempted to foster what we would now call ego development, and, in this sense at least, his work resembled the efforts of parents on behalf of their own young children. Although success with Victor was minimal, Itard's impact on the teaching and training of the retarded was significant. Many of his ideas were brought to America by his student, Sequin.

The case of "Little Hans" was quite different. One day, out on the street, this five-year-old boy suffered an acute anxiety attack. Thereafter his fright became more and more constricting; he could scarcely leave the house without an intense fear that horses, carts, vans, and the light might injure him or that they might themselves fall down and become hurt or broken. It was the boy's father, himself a student of psychoanalysis, who consulted Freud about the child's phobia.

The assumption of the treatment was that the anxiety and phobia were manifestations of a childhood neurosis resulting from unconscious conflict and consequent symptom formation. The unusual and rather delightful treatment plan that evolved was for Freud to treat the boy through his father, the two men reviewing the content of what father and son had discussed. Also pertinent to their work was the knowledge that, earlier on, Hans had evidenced a lively interest in his "widdler," and that this curiosity about his own anatomy gradually extended to his parents and to the sister who was born when he was three and a half. To those capable of understanding them,

Hans' fantasies revealed his efforts to try to solve the mysteries of his sister's conception and birth and the riddle of the difference between the sexes, as well as to control his own desires. But because Hans still lacked important information about reality, still lacked mature logic, and—most important—because of the conflicts aroused by his own wishes and fears, the child's private conclusions were problematic and distorted. As treatment proceeded, father and son would talk about the boy's fears and associated fantasies. These dialogues would be reported to Freud and discussed with him. Returning to Hans, the father would then further explore the small boy's conflicts. Gradually the misinformed conclusions and the unconscious conflicts they reflected were brought into the open. By providing the child with needed information and missing data and bringing the unconscious conflicts to light without resultant catastrophe, the phobia was dissolved. (It must be added that in a brief 1922 postscript [Freud, 1955] to the case report we learn of the divorce of Hans' parents subsequent to the treatment. We can only speculate that this parental discord must have had some effect on the development and course of the phobic symptomatology.)

It is these dual functions of educational training and psychological insight that have characterized child and adolescent psychotherapy from Freud's day on. Ever present in the child therapist's work are the roles of educator and psychic enlightener. Indeed, the mental and social immaturity that distinguish children from adults determine how these roles are mixed at

any one time in the treatment of a case.

The first American textbooks about child psychotherapy were written by Jessie Taft (1933) in 1933 and Fredrick Allen (1942) in 1942. Both emanated from Philadelphia and had considerable impact in this country. Both laid stress on the relationship between therapist and child, with the focus of therapy on the present. "Interpretation," wrote Taft, "there was none, except the verbalization on my part of what the child seemed to be feeling and doing, a comparatively spontaneous response to her words or actions which did clarify or make more conscious the self of the moment, whatever it might be." In other words, emphasis was on the here and now and on trying to help the child express his thoughts and emotions of the moment. No attempt was made to connect these to the historical past or to unconscious impulses. Virginia Axline (1947) also stressed the friendly relationship between therapist and child and the importance of accepting where the child was, emotionally, at the moment. But she more strongly underscored nondirective play and stressed a climate of permissiveness in which the child's thoughts, feelings, and ideas were allowed to unfold with little interference.

Beginning in 1927 in Vienna and continuing in London at the Hampstead Clinic, Anna Freud (1946; 1946; 1965) founded another line of child treatment based on the psychoanalytic model developed by her father. Initially she had trained as a kindergarten teacher, but then she became

curious about the psychological aspects of child development and child psychopathology. From her work grew child analysis and psychoanalytically oriented psychotherapy as we know them today. The essence of this approach lies in helping to acquaint the child with the connections between his conscious and unconscious processes; current play and past history are woven together through interpretation. The goal is to provide insight and thus to "free up" psychic energy and enhance the capacity for ego development. The relationship between child and therapist is still a "real" one, but today it is thought to contain many important transference aspects.

Melanie Klein, to whom Anna Freud credits the use of play as a medium of communication in work with children (Freud, 1965), is another important figure in the history of child psychotherapy. Although her ideas have never been particularly influential in this country, in England and South America they play an important role in the field of child treatment.

Adolescence, as a transitional period in life, has interested people for centuries, and many of them have recorded their own memories and observations of the period (Kiell, 1964). But scientific interest in it was relatively late to develop. (In 1907 the American psychologist G. Stanley Hall (1907) wrote a massive two-volume encyclopedic work on this subject which today remains only as an interesting curiosity.) During the last thirty years, however, we have seen a burgeoning of concern with all aspects of

adolescence, including a strong interest in pathology and treatment. In time it became evident that many of the techniques described in these introductory remarks are difficult or ineffective with many adolescent pathologies. Aichorn (1935; 1964) in Vienna was one of the first and most gifted of those working with adolescents to find in psychoanalytic theory a conceptual framework to explain what he had been doing successfully with delinquent youngsters. Although Blos, Sr. (1962; 1970), and Erikson (1959, 1969), both received psychoanalytic training in Vienna, they conducted their researches into adolescent development along divergent lines. Blos' primary interest has been the conceptualization of the adolescent's intrapsychic development, whereas Erikson has emphasized the interrelationship between psyche and society.

For many, these two lines of interest have resulted in a strong tendency to separate the treatment of adolescents from that of children, since they stress the recognition that adolescents present unique problems deserving special study. (We would add that visibility, pressure, and the number of adolescents with problems also contribute to this dichotomy.) The emphasis has been on three aspects of adolescence: the strong biological push at puberty (Tanner, 1962; Tanner, 1972); the separation-individuation phase of adolescence, marking the entrance of the youngster to adult society (Blos, 1972); and the interaction between the adolescent and society (Erikson, 1959; Erikson, 1963; Erikson, 1969). Some have felt these processes to be so

different from those of childhood developmental tasks that the period should be dealt with as a separate specialty (American Society for Adolescent Psychiatry, 1971). By discussing the psychotherapy of children *and* adolescents in a single chapter, we are not trying to turn back the clock. Rather, we are using this as a way of emphasizing the concept of development as a primary determinant in the practice of psychotherapy with both these age groups.

At the same time, we must acknowledge the conceptual wisdom in not only separating childhood from adolescence but also dividing each into subphases—infancy, toddlerhood, preschool, and the school years; and early, middle, and late adolescence, respectively. Here we may note that the phase-specific developmental problem facing each of these subphases is different, and that each subphase is developmentally related to the one before. Although relatively successful sequential resolution of phase-specific tasks is optimal in normal development, adolescence also offers some opportunity for the spontaneous reworking of earlier unresolved issues. Division into subphases has some validity in the selection of appropriate psychotherapeutic techniques, as well. For example, the younger the teenager, the more effective are some of the techniques that work well with children, whereas older adolescents can often be treated very much like adults. More will be said later concerning this.

With the upsurge of interest in adolescence have come changes within the psychiatric profession. Child psychiatrists have taken a growing number of teenagers into treatment, while adult psychiatrists have become increasingly drawn toward working with late high school or college students. However, while adult psychiatrists have often proved extremely adept in this work, many child psychiatrists feel that their thorough training in child psychiatry has better prepared them for coping with the problems of adolescents, especially the younger ones. In whatever ways these issues of professional competence ultimately evolve, developmental requirements will necessitate the attainment and mastery of special skills to meet the specific needs and problems posed by a patient in a particular age group.

Theoretical Framework

Although there are many ways of describing the development and workings of the human mind, we as clinicians have found in dynamic psychology the most useful body of theory for conceptualizing the problems with which our patients struggle. With this bias stated, we feel some obligation to the reader to acquaint him with the key concepts forming the basis for our thought and clinical work; beyond that, we must refer him to the working bibliography at the end of this chapter. For purposes of discussion, we will consider in turn the psychological, biological, and sociological systems within which the patient functions, suffers, and causes pain. (The order is not

to be construed in a hierarchical sense.)

We begin with those concepts that describe the psychic apparatus: the notion of the unconscious, and the constructs of id, ego, and superego. As detailed by Freud (S., 1953; S, 1961; S, 1959), Anna Freud (1946, 1965), Hartmann (1958, 1964), and others, these concepts enable us to understand the intrapsychic structure. Closely related are the concepts of intrapsychic conflict, the role of anxiety, and the defenses. Together they enable us to understand and assess the psyche in its dynamic aspects—its course of development (or non-development) as well as its weaknesses and strengths. (It is also necessary to take note of conceptual and cognitive development, as described by Piaget (Flavell, 1963; Piaget, 1969). However, attempts to integrate this body of knowledge with intrapsychic structures and clinical child psychiatry have hardly begun.)⁰⁵ As a related issue, it should be mentioned that there has been much interest in behavior modification and its roots in learning theory in recent years; but this has not been taken up with enthusiasm in the child psychotherapy literature (Blom, 1972).

To continue the discussion: the human psyche is housed in a physical organism, the body, which is presided over by a most complicated neuro-endocrine system. Biological factors to be considered include the organism's genetic heritage, rate and sequence of maturational development, physical health and diseases, and temperament (see below). Among the attempts to

relate these factors to psychological growth is the work of Gesell and his group (1941) in the 1930s and 1940s, with their systematic study and mapping of the psychomotor development of children and the valuable assessment scale that they devised. Valuable data concerning the sequence of pubertal development in the male and female have been collected by Tanner (1962, 1972). More recently, Chess, Thomas, and Birch (1968) have developed a concept of "temperament," a phenomenological term that refers to behavioral style; although they have not specifically investigated the basis for a particular temperament, we are inclined to place their concept in the biologic area. Others have contributed to the concept of individual differences, as well (Westman, 1973).

Finally, it is important to keep in mind that this psyche-within-a-physical-organism lives in a world, a social-cultural matrix composed of parents, siblings, peers, and society at large. Together, these three broad, interlocking arenas—intrapsychic, physiological and sociocultural—must form a homeostatic balance. Each individual attempts to achieve, maintain, and regain a balance between agencies of the mind, between mind and body, and between the inner and outer world. To preserve this dynamic equilibrium, the individual creates methods by which he strives with greater or lesser success to do this tripartite balancing act.

Obviously, artificial separations between these arenas must be made by

investigators for purposes of study and clarification, but the separation can result in a fragmented picture. For example, the sequential steps in acquiring speech (from the coo and cry, to the pre-verbal babble, to the spoken word) do not come about in a vacuum. They are interdependent with all other areas of development, such as hearing, vision, capacity to discriminate and integrate, memory, motility, attachment to significant persons, verbal stimulation, and so forth. An interesting research example of the more integrative approach is presented by Ritvo et al (1963). (The material comes from a larger, longitudinal study of the Yale Child Development Center.) Observational data provided by the parents are available from the prenatal period and include the baby, "Jerry," from birth onwards. Regularly collected environmental data from the home and later nursery school are presented. Intrapsychic information is obtained from Jerry's two-year psychoanalysis, begun when he was three and a half years of age because of symptom formation. The multidimensional interaction of nature and nurture is convincingly demonstrated (as is a certain continuing thread of high activity level, probably of constitutional origin).

Since the practice of psychotherapy must be grounded in the practical, we also stress that any so-called "normal" is an ideal. The reality is that even though the development of a single capacity does follow a regular sequential pattern, overall development is never an orderly, synchronous sequence for any single youngster. This is especially true for the one who needs

psychotherapy; in fact, one way of defining such a need is by the degree to which development has not been synchronous. Distorted development may show up as a lag of certain capacities or a precociousness in others (more commonly both), or a reaction to a traumatic event or inability. The overall task of psychotherapy is to correct the imbalance, help the youngster regain his appropriate place in the bio-psycho-social sequence of maturational processes, and help him develop operational methods to maintain the homeostatic balance suitable for his age and social reality. Of critical importance here is the innate push of such developmental processes, which acts as a silent assistant to the therapist. Or perhaps more correctly, the therapist is the needed assistant to ensure that the patient will indeed "grow out of it."

If psychotherapy is conceptualized as a method of modifying malfunctioning intrapsychic processes, then one can readily see that the request for treatment will come when the malfunctioning brings pain and suffering to the individual or causes problems for those around him, or both. (This approaches the medical model.) The patient's mode of dealing with difficulties may be predominantly autoplasic (acting to modify the self) or alloplastic (acting to modify the outside world). For example, one person may turn his problem inward and feel anxiety as a prominent symptom, which makes him very uncomfortable but does not necessarily disturb those around him; whereas a second person may be chronically provocative, which is

troublesome to those about him but not necessarily painful to him. Furthermore, in evaluating a patient for psychotherapy we must differentiate between types of malfunctioning, each with their own defensively-produced symptomatology. Is the malfunctioning caused by current outer stress (such as a parental divorce, a move to a new location, or a death)? Then perhaps brief psychotherapy can bring relief, help master the crisis, and offer a growth-enhancing experience. Or is the malfunctioning a continued effect of some traumatic event that occurred in the past? Is it a maladaptive defensive maneuver that may have been appropriate at an earlier time but has never been modified by subsequent events? Then perhaps longer-term, more intensive psychotherapy will be necessary. (A more ambitious plan in these instances may be to alter the character distortions that result from the prolonged maladaptation.) Or is the malfunctioning a learning disability based on a perceptual or integrative neurological misfunction, with a resultant psychological defensiveness and sense of inadequacy? Then perhaps special education techniques will have to be added when the psychotherapy has relieved the sense of hopelessness and futility and the youngster can engage in learning. Here psychotherapy may be prolonged to assist with a vulnerable sense of adequacy. But the length or frequency of treatment is not to be equated with effectiveness. Both short-term and long-term treatment, when properly selected, can be of long-standing benefit to the patient.

This chapter focuses on therapy for those youngsters who have neurotic or characterological disorders, and to some extent on those with psychophysiological problems. We do not attempt to deal with the treatment of infantile autism, severe psychosis, childhood or adolescent schizophrenia, or the seriously sociopathic youth, all of which we feel to be highly specialized areas of work. Nevertheless, much of what follows may indeed apply, with some modification, to work with youngsters who suffer from those illnesses.

Treating Children and Adults: Some Differences

Differences between psychotherapeutic work with adults and work with children and adolescents have been discussed in general terms. We would now like to explore several of them in more detail. One difference is the way in which children perceive or express their problem. As a rule, children are less capable of describing uncomfortable, neurotic symptoms. Rather, anxiety will be manifested by hyperactivity, and depression concealed by aggressive or provocative behavior. Often, too, children will tend to see their problems in terms of the outer world: "The teacher doesn't like me," "They all pick on me," "They make me go to school," and so forth. True, an occasional youngster will be aware of an inner pain, worry, or fear and acknowledge that he wants help with it, but this is not the rule. A corollary to this difference is the observation that children do not seek psychotherapy; it is rather the parents who do. Parents may initiate it because of their own concern about

the child's behavior or because they were pressured to do so by the school, the court, or some other social agency, as a consequence of the child's behavior. From the very start, then, because of the role of parents, the psychotherapy of youngsters is radically different from that of adults.

With regard to adolescent psychotherapy, the role of parents can vary. The adolescent may wish to seek out professional consultation because of his own concern, or he may get "dragged in" and see the problem as being outside himself. Either case may be a reflection of the in-between state of adolescence: a stage at which one is trying to become an adult but has not yet put his dependent childhood behind him; a time when many changes are going on—bodily, energetic, social, familial—concurrent with the demands of integration, separation, and reorganization of the psyche. At this age, dependency needs may be felt only to be cast aside—denied—because they are considered childish. The more disturbed adolescent feels even more concern about his mental and emotional condition. Any suggestion that he get help from a psychiatrist may be met with the anxious question, "Do you think I'm crazy?" Like his younger counterpart, only occasionally does the disturbed adolescent find his symptoms so painful that he accedes readily to the notion of getting help.

A second difference between the psychiatric treatment of youngsters and adults is the make up of the real elements which impinge on him from the

actual environment. The assessment of the world in which a child lives must include not only parents but also his siblings and any others who either live in the home or are very active figures in his daily life (relatives, household help, and so forth). It is well known that the person with the overt symptomatology is not always the most disturbed member of a family. A child may be used as a "ticket of admission" to treatment for a parent. A relative may be sexually seducing a child in the family, with the only overt symptoms being presented by the child. If the child's everyday world is one in which he is continually exposed to that which is harmful and destructive to his growth and development, then psychotherapy has little to offer. Neither children nor adolescents can do much to control the immediate environment in which they live. In situations where a noxious environment is unalterable, it may be the first order of business to arrange for nursery school, kindergarten, foster care, boarding school, or other residential placement. The younger the child, the more true this is; conversely, the older the youngster, the greater the possibility that psychotherapy can help in the adjustment to reality.

Obviously, parents hold a paramount place in a child's life and retain a measure of his loyalty no matter how "awful" they may be (Newman, 1973). Even in adolescence, when teenagers may show considerable rebelliousness towards parents, more often than not there is a deeply hidden but strong measure of attachment. Roles in the process of transition are complex for all concerned. It is also important for the physician to recognize that parents do

not just pay the bills, but that they are truly responsible for the youngster; therapist, child, and parents need to know and openly acknowledge this fact. Sometimes parents mistake the therapeutic process to mean that the therapist will take over parental functions with the child, and thereby abdicate their rightful role, maybe with resentment or maybe with pleasure and relief. In either case, the misperception must be clarified very early in the work.

A third difference between therapy for child and adult is the so-called "rescue fantasy." Here we allude to the feeling on the part of the therapist that he must literally "rescue" the child or adolescent from his "bad parents." Such fantasies exist also in adult work; but when one is working with children, the power of this countertransference fantasy is peculiarly strong and ever-present and can be insidious. For one thing, the child's actual parents are always readily available, thus inviting the unwary therapist to project his own disappointment in parents and parent figures. The implication, of course, is that the therapist himself will become the "good parent." Few things could be more damaging to patient or psychotherapy. Thus parents—except in those unusual cases in which their parental rights have been terminated by court order—need to recognize from the very beginning of treatment that they are extremely important to the whole therapeutic process, and the therapist must respect and mean this when he tells them so. Needless to say, parents need acknowledgement by the therapist of the stresses they too are experiencing

and of any past deficits for which they are now struggling to compensate (Halpern, 1963). It may also happen that, during the course of treatment, the child will talk or act at home in a manner that threatens the parents' own feeling of parenthood; this, too, may require help. There are some cases in which a child cannot live at home during the course of treatment—perhaps cannot even be returned to his parents when therapy is over. But these situations are comparatively rare and require special handling.

The Therapist

No attempt will be made here to define all that makes for a successful child therapist since no two will work exactly alike, nor will any two have identical personalities. Still, any successful child therapist will have a reasonably clear awareness of and psychological acquaintance with his own past. What is required is not a childlikeness on the part of the therapist but, rather, an open line from the adult person to the condition of being a child. It is important to communicate with children and adolescents without losing one's own identity, and to empathize with a patient's worries, feelings, and view of reality without identifying with them. With adolescents in particular, where the pressure so often takes the form "you're either with me or against me," the adult who can experience and express empathy without taking sides may be very helpful indeed. Even where we cannot experientially know life beyond our ken or the genital or bodily sensations of persons of the opposite

sex, it is very valuable when the therapist can acknowledge the existence and reality of the youngster's perceptions and assist in the development of verbal description.

In this connection we note that the ensuing comments on the technical aspects of psychotherapy with children and adolescents are intended to apply equally to the work of male and female therapists with patients of both sexes. In a small number of cases, as when a youngster expresses a preference for a man, or woman, as therapist, matching the sex of the patient with that of the therapist may become an issue.

Although little has been written on this particular topic, there does seem to be a professional consensus that the matching of like-sexed patient and therapist has its greatest significance for the pre- and early adolescent when such matching may prove to enhance the initiation and development of a viable therapeutic relationship. Where it is not possible, the alert therapist may, after all, allow this issue to be tactfully turned to therapeutic advantage.

Perhaps we can shed further light on what makes a good child therapist by asking: "What goes on in the mind of a child therapist while engaged in his work?" The process is not only complex, it also differs in certain respects from what happens in adult work. The therapist is engaged in play with the child. He may be actively playing a role, such as the wicked stepsister, the

helpless frightened child, the criminal, or the isolated bystander; or, with the early adolescent, there may be an earnest engagement about cars, hobbies, clothes, fashions, fishing, politics, the plot of a movie or a book, or the life of a celebrity or hero. Whatever the role he is cast in or the subject being discussed, the therapist must be genuinely engaged. If the therapist is not sure how a wicked stepmother behaves or what she says, the patient will be glad to write the script, or, if the therapist does not know much about cars or fishing, the patient will be happy to instruct. The therapist must also observe the play or the dialogue, looking for the prevailing theme and the inner, personal (latent) meaning it has for the child, such as anger, depression, fear, misinformation, sexual fantasy. Whenever there is a discontinuity or play disruption, the psychiatrist must try to grasp the reasons. And while all this is going on, the observing part of the therapist should also be correlating the current theme with earlier themes, with the patient's current life situation, and with his past history. What then follows is probably the most difficult task of all: when and how should the therapist intercede with verbal comment? We use the word "comment" here to denote a verbal communication, which may take the form of (1) clarifying questions, (2) comments on the play content, form, or thematic sequence, or (3) an interpretation that would link feelings discussed earlier, themes played out earlier, current life situations, unconscious impulses, or past traumatic events.

The decision as to what the therapist elects to comment upon and the manner in which he does it will reflect what he wants to accomplish. In short-term treatment or crisis intervention, where the focus is on clearly delineated problems, he will focus only on those aspects of the personality that relate to the current issue. In longer-term psychotherapy, he may decide to pursue more extensively the patient's hidden or disguised affects and those defenses that are constrictive or maladaptive for the personality. The goal will be to make the defenses less harsh and more useful, and to allow the patient more affective awareness, better reality testing, and stronger relationships with others. To use Kessler's (1966) example: a six-year-old boy gets into fights because he attacks whenever he fears being attacked, though unaware of the anxiety that began the whole sequence. The psychotherapist will try to help the boy become aware of his fear (anxiety), make the maladaptive defense of counterphobic attack no longer necessary, and clarify some of the misconceptions of reality. The psychoanalyst will want to go further and uncover the instinctual-drive derivative, the boy's unconscious wish to be attacked and (in this particular example) made into a girl, that is, castrated. Stated very briefly, the psychoanalyst believes that the uncovering of the id derivatives, coupled with defense analysis, will render the child less vulnerable to recurrent psychic problems, more able to deal with those that may arise later on, and emotionally stronger and more flexibly able to cope with his own wishes and the outer reality. Whether this formulation is or is

not correct and efficacious remains one of the many problems in the field of psychotherapy.

Youngsters in treatment must proceed in their own fashion at their own speed. Like adult patients, some are more intuitive than others and, given the chance, will almost "treat themselves." Some are far more cautious, and if pushed will only grow more and more resistant. Almost anything a child says or does—including body language, fantasy, the form of the play, and even lies—can add to the therapist's understanding of the youngster. Perhaps the most frequent mistake of the neophyte child psychiatrist is the effort to push the child into more adult-like verbalizations. Another frequent mistake is to permit the child unlimited freedom in the sessions, which may lead to either overexcitement or aggressive acting out. This only frightens the child, because it is painful and scary to feel out of control. It also distances the therapist, who may begin to feel irritated and withdraw.

Any discussion of the psychotherapist must include the phenomena of transference and countertransference. These concepts are vital to the treatment process, with children as with adults, but all too often they are ill-defined if not reduced to absurdity—as, for example, when positive transference is equated with the youngster liking the therapist and negative transference with his dislike of the therapist. Transference may be defined as those unrealistic feelings (whether positive or negative) that the patient

ascribes to his therapist, by means of displacement, but that more correctly belong to significant others in his life, such as parents, siblings, or teachers. They are thoughts, expectations, and feelings that are unconsciously directed toward another person—in this case the therapist—for whom they are inappropriate. Yet the patient always experiences these feelings as genuine and correctly directed. Transference phenomena occur in all relationships but are usually correctable by reality testing or are irrelevant to the transaction.

Certainly not all feelings about the therapist can be classified as transference. Many are genuine reactions to things the therapist says and does, or does not say or do. Others are projected and externalized feelings of the patient, which are attributed to the therapist. For example, a youngster's ambivalent feelings towards his parents are frequently split, with the negative, critical feelings externalized onto the therapist while the child virtuously defends the good parent. Or the child may feel the therapist does not like him, whereas in fact the child is projecting his own inner, harsh self-criticism. It is part of the therapist's task to initially accept these "slings and arrows" and work with them as though they were correctly directed. Then slowly, when the defensive posture is less necessary, the therapist will help his patient correct the distortion. For example, a girl of sixteen reluctantly acknowledged some mildly sexual fantasies about her male therapist, after having "put down" her father for some time. With her therapist's help, the girl's feelings of guilt, embarrassment, and pleasure about these fantasies

were explored. In this case, for a variety of reasons, they were not able to discuss the bodily sensations which probably accompanied these fantasies. When she was more comfortable with some aspects of her sexuality, the therapist attempted to interpret the transference—that is, to show that she also felt toward her father these feelings that they had been talking about, and that she did not see him only as fat, ugly and dumb. She denied it. Later, when the parents were in the process of separation and divorce, she visited her father, who was living alone. Suddenly she became aware of a complexity of feelings toward him, which included feeling sorry for him, wanting to take care of him, and sexual feelings. She was frightened, but she did not have to resort to the kinds of warding-off behavior (such as isolation, withdrawal, and disdain) that heretofore had interfered with many relationships, including the one with her father. In therapy she began to assess her father more realistically, and her view of men in general became less harsh.

The phenomenon of transference neurosis, on the other hand, has been described primarily in adults. It involves the patient literally, unconsciously, and with emotional conviction, displacing many unrealistic feelings, expectations, and attitudes onto the therapist. This temporarily frees the patient of the major part of his neurotic symptomatology, and the "neurosis in situ" becomes the working arena. There has been much debate over the years as to whether such a phenomenon can occur in children or adolescents. Though child psychiatrists and child analysts lack consensus on the question,

it seems far less likely that a true transference neurosis occurs in children. After all, the child still has his original love objects, namely his parents, and it would seem more difficult for him to transfer all of these feelings onto a therapist. But there is agreement that forms of transference do occur in the treatment of children and adolescents, and that recognizing their presence and working with the feelings and attitudes related to them may be critical to the success of the psychotherapy.

Countertransference phenomena are those feelings and thoughts that the therapist has about the patient, but do *not* belong to the real situation. Thus if a child patient means to hurt you by kicking or throwing something, and you feel an inner angry response, that is real. It is not countertransference. A seven- year old boy comes to his therapy hour on Valentine's Day, carrying nonchalantly a handmade greeting card for his therapist. In his haste he drops the valentine at the office door and greets the therapist cheerfully with "Hi, Dr. Fucker." If the therapist feels hurt and offended at the bad language and can not respond to the card lying on the floor, that is countertransference. The therapist's own emotions of distaste and social disapproval are aroused by the obscene word and obscure his ability to perceive the underlying message of endearment.

Play

Children, as mentioned earlier, express themselves most naturally in the form of play; and beginning with the early work of Anna Freud and Melanie Klein, play has been a *sine qua non* of child therapy. Erikson, who studied play as form, holds that it differs for boys and girls (1940; 1951). The boys he observed tended to play vigorously, constructing shapes and spaces going upward and outward; the girls created more enclosed areas and dealt with protected spaces. He felt that these differences were not just culturally determined but reflected real body difference. The meaning of play and its unfolding stories and themes can then be variously interpreted. But few would doubt that play reveals the inner life of the child, or that it is by means of play that the child can best communicate his fantasies about life and its processes, his fears, his hopes, and his desires. In addition, within the therapy hour the child will commonly use play as a way to master traumatic events or the fearful content of fantasy, to tell about unspeakable things, and to make gratifying (if temporary) changes in reality. But play can also be used as resistance, in which case the play functions to obscure and hamper communication.

When play therapy is planned, questions invariably arise as to what types of materials should be made available. Obviously the answer will differ with the age of the child. It seems a truism that the longer one has been treating children in play therapy, the more one trusts the children themselves to adapt available materials to their needs. For example, one of us has a

plastic wash-basket in the office that is used for storing toys. Children three to five years old have used it as a crib to curl up in, as a den for the wicked fox, and (upside down) as a cage to restrain a wild and dangerous bear. An older youngster, age ten, may ignore it as a play object and see it only as a utilitarian storage container. A twelve- or thirteen-year-old may spot it and decide to practice his basketball shots in it while he "has to see his shrink." Checkers, a classical game, also lends itself to multiple uses, depending on the age of the youngster (Loomis, 1957). The young child may use a checker to represent special food for a play animal or, perhaps, to construct a decorative tower for his building. He may try to assert his wish to be older by playing a real game of checkers, but with little concept of moves or rules. The child of latency age may also wish to play checkers, but as a way of concealing his problems and conflicts. Nevertheless he may reveal himself by how he reacts to the possibility of losing; he may cheat, disrupt the game, or try to change the rules (Meeks, 1970). For him the struggle for self-esteem is played out in the game along with issues of power, fighting, and being vanquished, a fear that winning will bring retaliation, or an inability to delay gratification. For the pre- or early adolescent the checker game may be intently focused on to keep his mind off disquieting things, or in a seemingly idle way he may stack the checkers as a wall between himself and the therapist while he talks about an emotionally significant event or situation. Even if a youngster only uses the game in a token way, he may feel more comfortable if there is something to

diffuse the contact between self and therapist.

Language is another aspect of play. With toys for his props, the young child may use language to elaborate the fantasy he is busy unfolding. The adolescent will use fewer props or even none at all. Instead the words themselves become a kind of prop as he talks with great enthusiasm about some current interest, some event that occurred, or some intellectual thought. These subjects are indeed current and real, but they also have latent content for which the therapist listens. Such a use of words is typical of early adolescents, who are often conflicted because they are at an in-between stage—above playing with toys, but not yet able to talk directly with the therapist without an in-between buffer. Another reason for the self-consciousness of early adolescents is that in their play they tend toward large muscle movement, which becomes awkward in an office.

In the practical matter of what kinds of play materials to have, we might offer two generalizations. First, the play materials need not be complicated and should not be highly structured. Second, they should be few' in number but carefully chosen for versatility of function. Plain wooden blocks of assorted shapes and sizes are excellent; for the younger child they should be of a fair size, similar to those used in kindergartens, because at this age the child is not adept with fine motor and eye-hand movement. Cars, trucks, and airplanes provide the element of movement. Dolls, including family figure

dolls of various ages and color, provide the *dramatis personae* for significant play. Some children prefer more distance from areas of conflict and tend to keep things in displacement by using animal figures for playing out family scenes. Hand puppets attract some youngsters as a means of telling stories or relating true events. While some therapists find a dollhouse useful, others prefer to use blocks and let the children build their own room-outlines or buildings. Beyond these, a variety of everyday items lend themselves to play, such as paper, cardboard, scissors, crayons, pencils, felt-tip pens, paste, tape, rubber bands, and paper clips. A range of things can be improvised from such materials without the need to buy particular toys. Truly, there are no limitations save the imagination of therapist and child.

Youngsters of all ages will reach for crayons as a medium of expression. The younger adolescent who is uncomfortable and does not know what to do with his hands will often relax visibly when given a pad of paper and a pencil so that he can "sketch" while he talks. If male therapists may sometimes seem more comfortable and adept than women at using toy soldiers and war-like toys it is less important than that professionals of both sexes can readily find the means for enabling youngsters to express aggression. With younger children the chance for water play is, at times, important, but on occasion we have worked quite successfully with imaginary water to produce an imaginary mess. A baby doll with a baby bottle and related equipment may prove inviting. A simple sewing kit or bits of cloth will sometimes tempt a

child to make clothes for a doll. And if the therapist proves as, or more, awkward than the patient in making miniature fashions that work, this permits direct discussion of skills and competence. Should sex-linked stereotypes be evoked, a therapist may turn his (or her) ineptitude to advantage by openness to these issues. Finger-paints, clay, play dough, and paper-mache are other materials that aid the development of fantasy as well as granting the permission to make a mess. Board games such as checkers, Chinese checkers, cards, and commercial games with pieces, dice, or spinners attract older children who often find things like "play dough" too "babyish" and need to avoid the seduction to such regressive play. At times children will bring their own games from home, and these too can be useful. Chess and Monopoly are two popular games that deserve particular mention. Both tend to last a long time and serve all too easily as a form of resistance. Yet one of us recalls a seven-year-old son of a real estate man who delighted in playing Monopoly and once, legitimately and with pleasure, made the therapist bankrupt in a single hour.

When space permits, it is useful to have a private place in the office for a youngster to store a project or favorite toys he may have brought to the office. An older child may elect to bring a copy of *Playboy* or some other reading matter that would not be acceptable at home. It is important that the therapist let the youngster know that while such materials are acceptable in the office because they help the doctor understand the curiosities of the child,

they are not necessarily acceptable elsewhere. Many children like to display their art work. This also provokes fantasies of sibling rivalry and concern about "who indeed is fairest (most beloved) of them all." Such youngsters may wish to write their names on their art work, but it is best to discourage the use of last names. When a child asks to leave an unfinished project in plain view, hoping to finish it at the next visit, he should be told that the therapist may not be able to preserve it in the interim. Pictures that the child displays on the wall may also not be as well protected as when tucked away in a folder containing only that child's material.

Many youngsters will want to take home with them something they have made. Often it represents the youngster's desire to keep some kind of contact with the therapist between visits. In general, it is best to have the youngster leave all such materials in the office but to let him know that he can have his own pictures back when treatment ends. As to taking play materials out of the office, our general rule is that this cannot be done (but this can be mitigated by developmental considerations). There is the practical reason that the toys are there for all to use. More important, the rule is a guard against acting out, and it assures discussion of the wish, its symbolic significance, and the urges that arise when a wish is thwarted. Most youngsters accept this, but some will occasionally pocket a small toy without the therapist's knowledge. Resultant guilt may then come into focus in the form of provocative behavior in the subsequent hour. As for adolescents, one

may find them "stealing" an object, however insignificant, from the office. The taking must be dealt with directly as a symptomatic act, with restitution as part of reality. One should be cautioned that not all taking is hostility; it may be concealed love, idealization, or identification. In related but different behavior, the youngster may seek the therapist's approval or sanction. But beware; the words of the therapist may be used as ammunition in a battle with parents or other authority figures. Being supportive of an adolescent's apparently valid complaint without taking sides requires skills worthy of a diplomat or negotiator.

On the question of office space, some therapists recommend a playroom that is well equipped and comfortable but that is furnished in a way that is relatively indestructible. This leaves the "grown-up" office as a place to talk. Such a luxury of space is not always available. Some therapists divide their office so that the "adult" part of it is on one side and a cabinet containing play materials on the other, a plan that has both advantages and disadvantages. For example, many children are fascinated by things like a telephone or a dictating machine. If a youngster happens to be aggressive and to have negative feelings toward the therapist, he can play havoc with these instruments. On the other hand, the same instruments have brought many therapists' important revelations. For instance, a child who can use a dictating machine properly can often be urged to tell a story into it. The same holds true for a telephone if the child agrees to let the therapist hold the button

down.

We believe that many questions concerning space and play equipment relate in part at least to temperament. Some children are extremely innovative, clever, and capable of imaginative games and constructions with a minimum of play materials. Others will complain of the lack of certain games or toys, often with the unspoken wish to see if the therapist "loves" them enough to get the missing materials. For ten years, one of us treated children of all ages (in the same office space where he saw adults), and the fact that the desk or book shelf was "off limits" never seemed to inhibit the child's freedom of expression. In fact, curiosity about the desk was invariably a way of indicating curiosity about the therapist himself. Nevertheless, if issues of space and equipment reflect the temperament of the children, the same is true for the therapist too. Some therapists are just not good with puppets, others find board games a bore, and still others find that chess can divert them too much, so that they lose track of what is going on in therapy. Each must choose his own play tools and admit that others just do not catch his interest.

Parents

Legion are the therapists who have felt, "If only he had other parents, I could really help this child." This is true whether the patient is six or sixteen.

Indeed, some physicians have given up the practice of child psychiatry because of parental "interference" that they saw as beyond their control. The feeling is understandable. But periodically it helps for the physician to remind himself that parents do indeed have the last word, and surely no one would contest the fact that the treatment of any minor who is still in the custody of his parents must have their tacit backing. At this point it is important to mention several still- changing aspects of the term "minor." First, the age of majority is now eighteen instead of twenty-one in many states. Second, there is a growing lack of consensus about the age at which the teenager may demand his own legal counsel (this has to do with the pressuring of a youngster into treatment, as in residential treatment), or the age at which he may enter into a psychotherapeutic relationship without parental knowledge or consent (this pertains to "drop-in clinics" where adolescent clients are seen and may even be encouraged to enter into a longer term therapeutic relationship). While it is to be hoped that some of these confusions can be clarified legally in the next few years, things remain in flux for the present.

To return to the alliance between parents and therapist, a collaborative relationship exists even if they never see each other—as is recommended by some in the treatment of adolescents. It is our feeling that the majority of teenagers will do better if their parents' acceptance of the treatment is direct and openly acknowledged. We believe that a smoother therapeutic course, one less likely to be threatened by disruptive parental actions, is well worth

the investment of a few extra hours in the initial work-up in meeting with the parents. The short-run gains are obvious, for it is clearly better to have obtained parental cooperation ahead of time than to begin the work while they are ambivalent or openly resentful. But long-run gains may be more important. For example, if the therapist shares with the parents the prediction that their child may appear to be getting worse as his emotional constriction begins to lift, the parents' unhappiness may be spared and their disappointments kept from being vented on the child.

It is not difficult to be responsive and sympathetic with the parents if one keeps in mind that most parents who come for help with their child are under pressure (Anthony, 1970). Somewhere, somehow, they feel they have failed (Halpern, 1963). Hence, the therapist is initially perceived as a judge of how well they have done their job as parents. Soon they may begin to fear that the child will prefer the therapist to them because he is sympathetic, understanding, and non-demanding. Jealousy may develop, along with a growing sense that the youngster shares more with the therapist than with his parents. It is at these times, when many parents feel vulnerable because their child has an ally who knows things about the child but will not share his knowledge, that a "rescue fantasy" on the part of the therapist can be especially dangerous. But if parents can come to know that the therapist understands their position and plight and respects them as people—in fact relies on their help and tacit support— they will be much more cooperative.

This is true even where there are disagreements between parents and therapist about child-rearing practices.

Specific aspects of the therapist's relationship with the parents will depend on the age of the child. For example, because it tallies with his everyday life, the youngster between the ages of three and six is rarely troubled by the fact that the therapist is in regular communication with his parents. It is often hard for the young child to recount important events of the week, so the therapist relies on obtaining parental information on a regular basis. Again, knowledge of a difficult weekend at home, a fight at school, parental illness, an accident, an absence, or even a particularly successful handling of a difficult situation can often help the therapist make better sense out of events that occur in the sessions. Nor do we hesitate to share such information with a child. This is because he looks on the therapist as a helping person, and the discussion or play that may follow will make the child's anxiety more manageable and lessen his more inappropriate defenses.

Developmental processes in the youngster from ages six to ten move him into the world of his peers and of adults other than his parents. The size of his private world is literally expanding. Stronger assurance can now be given a child, when he needs it, that although the therapist may talk with his parents he will disclose nothing of what goes on between himself and the child. This is usually termed confidentiality (Ross, 1958). It is unwise to make

these assurances absolute and unconditional, since promises of confidentiality may sometimes have to be "bent." Even at these ages youngsters assume that the therapist will have some communication with his parents. Many will conclude on their own that, despite this communication, they do in fact enjoy confidentiality; if not, then the child's fears and worries about what will happen are well worth exploring. It is common practice to furnish the youngster with an explanation of why the physician talks with his parents from time to time. He can be told, for example, that the doctor needs to know about events that happened so early in his life that he cannot remember them, or perhaps other things that his parents would be more aware of than he is himself. All of this should be explained to the youngster in a way that helps him to understand how it will aid his therapist in understanding his problems. (One can also acknowledge that parents sometimes need help in understanding their children and knowing how' best to deal with them.)

The picture changes somewhat for the pre- and early adolescents. At this stage of development there are often sharp differences between parent and child, which provoke arguments, angry outbursts, and even periods of intense withdrawal. Youngsters are now prone to see one as a person who is either for or against him, and alliance by association is quickly seized upon. The therapist must, therefore, ally himself more specifically with the youngster than his parents, but never exclusively so. At no other time in the

life cycle does a psychotherapist tread a finer line than with these youngsters, and never are the guideposts more camouflaged. The therapist should be available to parental phone calls that are often about extraordinary events that the patient "forgot" to tell the therapist. Examples would be an explosive fight with his parents, a threat to run away, a suicidal gesture, or even an especially happy time or a good report card. These should be brought up in the treatment situation in a sympathetic manner, because they indicate the youngster's unhappiness or despair or his conflicts about success.

We would like to emphasize that the youngster's therapist, no matter what the age of the child, should strive always to deal with the parent only as parent and not as patient. This means discussing the parental role, behavior management suggestions, and support for maintaining parental function and authority. It does not mean exploring the personality, motivations, or psychopathology of the parents. If these *are* required, as they often are, either psychiatric social casework or psychotherapy for the parents can be a valuable adjunct to the child's treatment process. If circumstances are such that no one else is available, and the parent is in need of psychotherapy, then careful consideration must be given to the possible ramifications and complications of being psychotherapist for two or more members of the same family at the same time. For example, one thirteen-year-old patient threatened that he was no longer coming to treatment because it was useless. "My mother makes me come," he said, "and I won't come unless she does too."

(The parents had divorced and the father had subsequently died.) Attempts to explore the reasons behind this challenge were to no avail. As far as the boy was concerned, either both came or no one; faced with such an ultimatum, one could only agree. In this particular case it was fortunate that his mother, although in treatment herself, went along with the plan. There followed six months in which the therapist witnessed a full array of vicious battles and threats, followed quickly by tearful and emotional reunions. This, however, allowed the physician to begin to work out a most tangled relationship so that both people could begin to separate and live as autonomous persons and subsequently return to individual psychotherapeutic work.

What about the other side of confidentiality? This is an area that has been little discussed in the literature of child and adolescent psychotherapy. What stance do we take when we learn from a five-year-old patient that he is heavily but secretly involved in neighborhood sex play, and while he claims it is lots of fun, there is much to indicate it is making him highly anxious? What is our role when a ten-year-old discloses with considerable hesitation that he is involved in a local extortion racket at his school but cannot break free? What is our role when a fifteen-year-old girl confesses to her therapist that she is pregnant and her friends are collecting money so that she can go to New York for an abortion? All of these, in our opinion, are cries for help—help that, for the most part, only parents are qualified to give. In instances where the parents have unwittingly failed to protect their child as he deserves, or

the youngster has not dared to solicit their help, the therapist should provide such moral and emotional support as will enable the child to broach the subject with his parents. With a younger child, after the therapist has talked it over with his patient, it may be best for him to discuss the situation with the parents alone. They can then help the child with his ambivalent wish to get out of an overstimulating situation. For example, one five-year-old very adroitly maneuvered one of her parents into the office and, in the ensuing doll play, proceeded to demonstrate graphically the sexual games she was then engaging in with a male playmate. The parents, who had earlier been skeptical when the therapist had raised the possibility, were now satisfied that the quietness in the basement and outdoor playhouse needed closer monitoring.

With older children it may be best to invite the parents in for a discussion, with the child participating. Correct judgment in such cases may be difficult, but more often than not a frank discussion with the patient will bring the hidden call for help to the fore. A fifteen-year-old boy comes to mind who had been in treatment only briefly when he made a moderately serious suicidal gesture. That evening (after appropriate medical care had been rendered) he was interviewed with his parents, and while the gravity of the situation was noted, the decision was that there was no need for hospitalization. Two days later the youngster announced that he was fine and was discontinuing treatment. At this point, the therapist indicated to the

youngster that he was forcing his hand and that if he could no longer come voluntarily to therapy, there was no choice but to hospitalize him. The boy was frightened and angry. It took six more months of treatment, while in the hospital, before he could reveal that several weeks before the suicidal gesture he had told his parents that he felt only hospitalization could help his depression and isolation. When they made light of his plea and tried to reassure him, he interpreted it as the usual parental reaction of not taking him seriously.

School

The psychiatrist who works with children and adolescents inevitably must have contact with our largest social institution, school (Millar, 1965, Skurow, 1973). In fact, school can be considered the third point of a triangle that confronts the psychiatrist, the other two being the child and the parents. When it functions well the triangle is effective, growth enhancing, and very sturdy (a characteristic shared with all triangular structures). The child psychiatrist needs to be aware of these three points and the interplay between them, although his primary attention, of course, is directed to the individual psychotherapeutic work. If the psychiatrist knows something about the schools in his area and has had contact with key persons in the local school system, his task will be easier.

A youngster's behavior or achievement at school is frequently one of the primary complaints that brings him to us for evaluation. Whether it is poor achievement, disruptive behavior, truancy, or excessive withdrawal, all are symptoms the school recognizes as signs of trouble. As a usual first step, parents are invited by the teacher or counselor to discuss the problem. Then, if things do not improve despite the involvement of school personnel, child, and parents, referral is made to a child guidance clinic or private psychiatrist. In the ideal situation the perceptive teacher would recognize a youngster's need for help, have the backing of her superiors, and discuss the recommendation with the parents, who would readily and comfortably authorize the school to share with the psychiatrist its knowledge of the child and of pertinent aspects of his academic and social behavior. However—the ideal being infrequent—it is worth mentioning some common variations. For example, there is the situation complicated by parents who side with the child to such a degree that they can only regard the school personnel as being at fault or incompetent. Conversely, the teacher may see the parents as overindulgent or unwilling to recognize obvious problems. In either or both of these polarized relationships a psychiatric consultant may find himself being asked, however subtly, to take sides. Here, as in divorce struggles, he should be prompt to make the problem explicit and make clear that his task will be to try and determine what will be best for the youngster.

Once the referral for consultation has been made, the school is usually

willing to share its observations and test results with a psychiatrist, given the parents' permission. School data are for the most part observational and have to do with problems and styles of peer relationships and the ability to concentrate, to recall, and to reason. Also described are odd or persistent habits or compulsions, how the youngster relates to adults, and so forth. A good teacher-observer can provide excellent vignettes of a variety of ego functions in action. These are not likely to be couched in psychiatric terminology, but they often prove invaluable in assessing a child's personality. Grades and group IQ test scores are usually less valuable except as they reveal trends or sudden discontinuities. This seems as good a point as any to mention that we usually let a youngster know, if he is eight or older, which people we are asking information from and why.

At the conclusion of the evaluation it is important to give the school some feedback, with the consent of the parents, and after an age- suitable discussion with the child. However, the information furnished should not be in psychiatric jargon but in precise, descriptive English. In general, diagnoses are not as valuable as are suggestions for management in the classroom. One should not release data about family, parents, and patient—however important such data are to understanding the case dynamically—if they will be of no help to school personnel in their daily management. What the school can do to help is, however, a valuable part of the overall treatment plan. It may be a change in classroom, remedial education, or active teacher support

for early intervention as the student's behavior spirals. At times the school may provide realistic punishments and restrictions; at other times, a "safety valve" way of getting out of the classroom, or other ways of temporarily restructuring school routines for the child. Of course it should go without saying that *no* sharing of information obtained in circumstances of confidentiality should occur without first having cleared the matter by discussion with the persons involved—that is, parents and child.

There are times when a youngster needs to be confronted with discomfiting realities. Unfortunately, too many schools consider the child in treatment to be very fragile and, as a consequence, avoid revelations of unpleasant truths, thus keeping the child in limbo. It is important, although difficult, for the therapist to make clear to the school that it need no longer protect the youngster, that indeed he has to become aware of the consequences of his actions (or his failure to act), and that usual rules should be followed—which is not to say that the school should be harsh; merely honest and just. Strategically, this task may be quite difficult for the therapist. Great care must be taken, on the one hand, that the school will not misuse the therapist's sanctions, and, on the other hand, that the therapeutic alliance with the child will not be damaged.

Sometimes a child will be brought to treatment when there are no manifest problems at school. Then we feel it quite appropriate to omit contact

with the school and to rely instead on reports of parent-teacher conferences. This is a different situation from the one in which the parents are very reluctant to have the psychiatrist contact the school because they fear a social stigma. Occasionally the parents are right in their opinion that the school teacher or principal is actively judgmental against the youngster's need for treatment, or openly prejudiced against psychiatric intervention. More often, however, such an attitude proves to be a parental rationalization that must be dealt with and that represents a projection of the parents' feelings toward, and rejection of, psychiatric care.

Utmost cooperation between therapist, parents, and school is required in the treatment of the symptom complex called "school phobia," or "school refusal" (Finch, 1960; Johnson, 1941; Malmquist, 1965; Waldfogel, 1957). Assuming, of course, that it has been established that the child is not psychotic, the first task is to get the child back into the school. It would not be inappropriate to define the initial phase as an emergency situation requiring extraordinary amounts of attention and attentiveness to child, family, and school. Because all those concerned are feeling anxious and unsure at this time, the therapist must not only supply a rationale for his difficult prescription (the return to school) but also concrete suggestions for case management. The most useful stance The child must enter the school building even is to be kindly and supportive but also firm, if he only sits in the principal's or counselor's office to do some school work; the therapist can

acknowledge the anxiety feelings—including preschool nausea and vomiting—of the child, support the parents' understandable fear of hurting the child, but remain steadfast in his insistence that it must be done. A physical examination by the family physician that gives a clean bill of health is helpful in assuaging dire catastrophic fantasies that child, parents, or school officials may harbor. The child can express his rage at the psychiatrist for "not caring" and for causing him such suffering. When things are no longer acute, the therapist may withdraw from his contacts with the school and direct all his efforts to the psychotherapy. Parent therapy may also be necessary after the acute issues have been handled.

One word of caution: under the laws of professional confidentiality, all school contacts require clearance from the parents; in addition, the rights of the adolescent to confidentiality are changing even now. In this connection it is important to keep in mind that, in certain states, parents may see all school records simply upon demand. Written reports must be carefully composed so that they contain only such relevant data as the school needs in its program planning for the youngster. (For instance, data about extramarital affairs of a parent, illegitimacy, adoption, marital discord, and so forth, have no place in such reports. Neither is it relevant to include details of a child's fantasy life, secret sexual experimentation, and so forth.) As a safeguard, we think it is wise to discuss with all parents and older children the recommendations that the school will receive from the psychiatrist.

Common Technical Problems

Among the technical problems unique to the treatment of a youngster, some are more typical of one age than another. In the following discussion each will be touched on from a developmental point of view.

Limit Setting

At some time in the treatment of almost every child, the endurance of the therapist is put to the test. With a young child this most often takes the form of attacks on the doctor's person or on objects in the room. While motivations vary, such behavior usually stops if correctly defined and interpreted. It often helps to divert the behavior onto dolls, puppets, or other appropriate objects. But there may come a time when none of these methods work and the child must be physically restrained. The therapist may then be surprised to find that the patient struggles *into* his lap instead of away from it. It helps if the restraint comes with a clear, definitive statement from the therapist that he will not let the child hurt him but also that he will not hurt the child. Youngsters who are out of control are often both angry and frightened. They find it reassuring to know that the therapist will control them at the moment and later suggest alternative modes of expression such as words or play. It is essential that the child feel himself being controlled without the therapist's opinion of him changing.

Older children may not lose control as frequently but are more difficult to manage when they do. Because the chances are greater that either the therapist or the child will be accidentally hurt, stringent efforts should be made to avoid this outcome. Shunning direct physical contact, older children will resort to methods such as "snitching" things from the office, cheating at games, and so forth. At such times, limits are best and most appropriately set in terms that let the youngster know that the therapist is aware of what is going on and that it raises questions in his mind as to the youngster's insecurity and sense of unworthiness. When a ten-year-old cheats in a checker game, the therapist may suggest that since he (the therapist) is older and has played more, he would be willing to take a handicap. Some youngsters can accept this and some cannot. The therapist may then inquire as to whether the youngster would prefer to play by his own rules or the real rules, getting across to the youngster an awareness of the youngster's absolute need to win.

With an adolescent, these problems may take the form of lying or distorting the truth. Here the situation becomes somewhat delicate, because to accuse a child of lying is apt to provoke more open resistance. Instead one may, for example, tell the youngster that apparently he wishes so desperately that certain things were so that he comes to feel they really are so. This lets the youngster know that the therapist is aware of what is going on and understands the psychological motivation, but it avoids direct accusation,

which could only be understood as disapproval.

Resistance

To resist, to want not to know, is part of all psychotherapy. It means that the patient is unwilling or unable to learn more about himself through sharing his thoughts and feelings with his therapist. Although at times this may be conscious and deliberate withholding, more often it is unconscious. Also possible is the preconscious existence of a memory of an extent, thought, or feeling that may be lost from awareness, only to reappear later. If prodded by the therapist, the patient may easily recall the memory (even if only to dismiss it as unimportant). The only generalization we can make is that any mode that can be used to express oneself can also be used in the service of resistance. Play can become dull, repetitive, and confusing. Drawing can become stereotyped and abstract. Game-playing can become strict, repetitive, and unemotional. Each is a form of resistance. Resistance may also shade into long periods of silence during which the youngster claims he has nothing to say (Blos, 1972).

We find there are several distinctions that help in dealing with resistance, no matter what the age of the patient is. (1) It may be a defensive maneuver to protect the youngster from fantasied punishment at the hands of the therapist, whether it is based on pure fantasy or on actual experience at

the hands of other adults (transference). In such instances it can be valuable to talk about the fantasy and feared dangers before the thought or event the youngster has in mind can be revealed. (2) Resistance may be expressing some conflicted loyalties, often related to a family secret that no one is to tell. Either directly or indirectly, it has been gotten across to the child that a certain fact or event must remain a secret and thus cannot be shared with the therapist. (3) For the latency-age or adolescent youngster there may be conflicts about peer loyalty; in such cases it is useful to discuss the loyalty issue, which is often part and parcel of concerns about confidentiality (Ross, 1958). With children perhaps six to eight years old, one may need to discuss with parents the child's need for them to allow him to speak of anything in treatment and to let him know that secrecy *vis-à-vis* the therapist is not only unnecessary but contrary to his needs. Younger children—that is, those who are about four to six years of age—have trouble keeping secrets anyway. Often they reveal in speech and play many of the intimate details of what goes on at home. (4) On occasion, resistance is found to be an expression of anger at the therapist, and the withholding is then an effort to blackmail or retaliate. Finally (5), there are situations, most common in early adolescence, in which resistance is a defense against the patient's fears of an emotional outburst or a torrential pouring-out of dammed-up material. Here it is best to deal with the feared danger and to discuss with the youngster what he feels would happen if this material were revealed, rather than trying to get him to talk

about the content directly.

It should be emphasized that resistance is not "bad behavior." An essential process in the healthy psyche, it is mobilized by dangers perceived as coming from the outside. Although the therapist offers verbal reassurance that anything may be said in the office, such permission is often insufficient. The youngster in treatment may feel transference threats in the therapeutic situation, and he needs to assess them. In fact, if one sees a child who is ready and willing to tell everything about himself without reservation, it should be cause for concern, for this may well be a sign of an ominous prognosis.

Hours and Frequency of Visits

There is no way to predict the exact number of hours that should be given to any one case of psychotherapy. In general, if one elects to do short-term intervention, one might see the youngster six or seven times on a weekly basis, with perhaps one or two hours spaced farther apart toward the end. One must then have clearly in mind that this is a time-limited task, with the end of the treatment program remaining constantly in focus. At times one may misjudge the child's (or even his immediate environment's) capacity for change, and one may have to revise initial recommendations in favor of longer-term treatment or other types of intervention.

Long-term intensive psychotherapy may vary from one to three hours a

week over a period of many months; psychoanalysis requires four to five hours a week for several years. A variety of factors determine the plan, but prescription writing—as in so much of psychiatry—is not possible yet. For instance, one hour a week may not be enough, because continuity is more easily lost and because the infrequency makes it difficult to keep up with events in the child's life. Having twice-a-week sessions, in our experience, seems more than twice as effective as seeing the child once a week, though we have no statistical studies to prove it.

The conventional length of the psychotherapeutic hour is forty-five to fifty minutes. But with certain youngsters, particularly young ones, the closing of the hour may be difficult, and one should allow extra time for this in one's schedule. In other cases a youngster, for one reason or another, may be unable to tolerate more than perhaps twenty-five minutes. Each case has to be judged according to its own particular needs.

Many youngsters, particularly those in latency and adolescence, look upon school vacations as a time to interrupt the psychotherapy and will make a prominent issue of this. Somehow they associate therapy with school attendance and feel that when there are school holidays, therapy should also be interrupted. Often one can deal with this as direct resistance and use it as an opportunity to point out the purpose of psychotherapy. For example, a ten-year-old boy who wants to have all his days free to play baseball in the

summer may have to be reminded that his troubles at school (such as not paying attention, forgetting, and in general not doing as well as he wishes and is capable of), which have made him so unhappy and frustrated, have not ended just because school is drawing to a close. His wish "not to know," "to forget," and "to put off" is actually a part of his problem with learning, his difficulty with tension tolerance, and his fear of discovering that he is really "inadequate" or "damaged." As another example, a seven-year-old girl wishes to interrupt treatment over the school's Christmas holiday so that she can play with her friends. She adds quickly that she will come back when school starts. Yet she still has problems with her temper and gets into provocative fights with boys and her father. The threat of temper if she is thwarted hangs in the air; from earlier data her therapist points out her desire to have a "fight" with him, her need to be in control, and her wish to retain her therapist by prolonging therapy. He stresses the importance of continuing their work even though it may upset her, in order that her temper, which causes her so much trouble, can be tamed. She then starts a puppet play that evolves into a modified Cinderella: the rejected, mistreated girl who triumphs by winning the prince's hand—with the help of the fairy godmother (the therapist).

There are times when it may be appropriate to allow an interruption in treatment, but the therapist should then verbalize his reasoning. For instance, a youngster who has had few friends is invited to a birthday party or an

overnight visit. It may be more important, therapeutically, to let him socialize than to insist upon his keeping his hour. Another example would be that of an adolescent girl who mentions on Wednesday that on Friday she is going out on her first date and must cancel her Friday appointment, because otherwise she will have too much to do to be ready on time. It would be poor strategy to insist that she keep her hour and perhaps be late for the party. Nevertheless, one might discuss with her why she did not mention the party earlier, or ask for an alternative appointment. In this way the therapist would indicate that he is indeed in favor of her evolving social life, but would also let her know that some resistance may be advisable.

Food and Gifts

Many therapists have candy or snacks on hand in the office because they feel this is important to children, but child psychiatrists differ widely on this point (Hartmann, 1958). There are those who feel it is quite possible to do psychotherapy without snacks. Others feel that this type of feeding may be important, particularly with certain children who are especially "hungry." All would agree, of course, that merely to feed the child candy or snacks without meaningful talk or play is incomplete treatment. But beyond that, feeding can create problems. For example, a youngster may gorge himself on sweets and candy to the point where the psychiatrist becomes concerned about the effect on his overall dietary intake as well as the possible result of dental cavities.

(Some have tried to solve this problem by using sugarless candy or fruit.) Thus the neophyte child psychiatrist should be wary of using candy or snacks as a means of gaining "friendship" with the child, only to find himself later in a situation that is hard to control. Some child psychiatrists resolve the problem by having a very limited amount of food openly available and keeping the main supply elsewhere, so that even if the youngster eats everything in sight, he will not have consumed an excessive amount.

Gift-giving poses similar problems, and again one finds a divergence of opinion among therapists (Levin, 1966). Some rarely, if ever, give gifts (except perhaps to very young children), while others feel much more comfortable about the practice. The problem can be looked at developmentally: until they are about seven or eight years old, children have come to expect gifts—no matter how modest—from important adults on birthdays, Christmas, or Chanukah. A child of this age would certainly feel very deprived should a favorite person not respond in some way on such occasions, nor would his ego be of sufficient maturity to profit from the failure. But with older children, one may decide not to give gifts on special occasions, as an indication that the skill and interest the therapist offers make for a special working relationship where love and appreciation are not expressed by gifts.

This brings us to the perennial problem: if one chooses to give gifts,

what is the right type of gift? For example, what does one give the youngster of nine or ten who is the offspring of a wealthy family and can have what he wants? If such a child is then confronted with the more puritanical standards of the therapist, this could provoke some realistic frustration that he might respond to, rather than the endless gratifications that have surrounded him at home. (And it might indeed be difficult to find this child a gift that he would not demean.) If, on the other hand, the child comes from a deprived family, then the giving of a gift may have quite other meanings. In this case one must be aware of the impact the gift may have on the child's family. His siblings may be jealous and his parents may feel guilty at not being able to provide the kinds of things that the therapist is saying implicitly their youngster should have. Some child psychiatrists resolve the issue by merely sending a greeting card, especially to youngsters of latency and adolescent age. Our own feeling is that the best and most important gift the therapist can give to a youngster is his interest in the child and his well-being. If the therapist decides to give a present, it should be modest and should fit the therapeutic process itself. For example, one little girl who was approaching her fifth birthday had been discussing at some length her curiosity about procreation, birth, and the question of her own origin. With this in mind her therapist gave her a brightly painted wooden doll, in the Russian style, that had one doll within another doll within another. An older youngster of twelve, who had a reading difficulty but who had made considerable progress after hard work in both

remedial reading and in therapy, was given a book that she was quite capable of mastering; it was also a book whose theme and heroine were apt to strike a responsive chord within this child.

One final complexity can be the youngster's giving of gifts to the therapist, with or without the assent of his family, which can easily lead to the parents' and/or child's concern about who gave whom the better gift. This can be a very delicate issue that involves not only aspects of competitiveness but also genuine feelings of gratitude, affection, and love. Whether to accept or not, how to accept without letting the transference aspects get lost, how to refuse the gift without generating feelings of personal rejection—all are difficult strategic problems that require very tactful and empathetic handling.

Phases of the Therapeutic Process

Initial Phone Call and Evaluation

For the child or adolescent the opening phase of psychotherapy begins when either the parents or the adolescent first begin to think of getting outside help. How this comes about—whether by internal awareness or outside suggestion—and how this is related to and then acted upon, will be important in determining the various states of mind that the psychiatrist will confront at the first meeting.

The decision to ask for help is critically important, and psychic change is apt to take place in the family even as early as the first phone call requesting an appointment. For example, there may be relief and hope because something finally is going to be done, however differently each person may picture the optimum resolution. The youngster may fear punishment or subtle coercion, while parents struggle with a sense of shame at having failed in the tasks of parenthood (Anthony, 1970). The hopes raised may be just as magical and irrational as the fears. In fact, all these emotions may exist side by side or be split among family members. How the psychiatrist handles all these various and contradictory expectations in the early visits will have important repercussions. In fact, we would underscore that the initial consultative visits should be seen as occasions in which parents can raise questions to help them find out whether the problem has been brought to the right place and, if so, what would be the best plan for evaluation.

The purpose of an evaluation is to study and assess the various aspects of the problems presented. The evaluation may need to include psychological testing, educational evaluation, EEG and neurological examinations, school reports and other relevant studies, and medical tests or reports. All of these become part of a psychiatric evaluation—data that will enable one to understand the problem and make a diagnosis, resulting in appropriate recommendations. How long the process takes and what it entails will depend on a variety of factors. Foremost will be the urgency of the need for action

(often grossly over- or underestimated in work with the age groups we speak of), the available financial resources, the confusing nature of the problem, or other special aspects. Nevertheless we would agree with McDonald (1965) that an evaluation is a finite process that ends when the psychiatrist presents his findings to the parents and discusses his recommendations with them.

There is no question that psychic effects are created—therapeutic or otherwise—by the referral to a psychiatrist and by the consultation and evaluative process. Perhaps we are stressing the obvious when we say this is not psychotherapy proper. But all too often we have found, to our dismay, that a psychotherapist has begun treatment while the parents and the patient have not yet openly contracted for it, with the result that all are working at cross purposes.

What is the role of the youngster in this stage of the process? We would again differentiate in terms of developmental stages. Children in early childhood (up to age eight, let us say) see their parents and other adults as authorities: benign, malevolent, or something in between. Another characteristic of these younger children is that their reasoning powers are such that their thinking is still fairly concrete and is oriented to the here and now. This is not to deny their often excellent capacity to question and articulate the obvious or the sham, their sharp observational powers, and their often refreshing directness. But they are not yet in the habit of being

included when their parents consult other adults on their behalf (to set a medical appointment, arrange for a parent-teacher conference, and so forth). A child does not feel offended or threatened when he is not included in these adult exchanges. In the case of the psychiatric evaluation, his parents are interviewed first; this sanctions the child contact that follows. Parents also give important historical data, providing the therapist with a context within which to view the young child. The diagnostic results and the recommendations are discussed with the parents first. Then, depending on what the actual plans will be, the psychiatrist should discuss them with the child in language that he can understand. Treatment recommendations, if accepted by parents, are usually accepted by children of this age group without much difficulty. More specifically, although a child comes with his parents, it is up to the therapist to arouse the youngster's interest and overcome expectations derived from previous poor experiences with adults.

As children grow older, they tend to become more involved in decisions that affect their immediate lives. Whether the issue is a paper route, a summer camp, neighborhood boundary limits, bedtimes, or entry into psychotherapy, their wishes and views have a growing impact on what they will do. Also, youngsters in the age range of eight to twelve may be quite reluctant to involve themselves in the evaluative stage or the actual initiation of treatment, whether for reasons of shyness, of natural reticence, or of outright resentment over and resistance to what is viewed as an intrusion.

Adolescents may show reluctance for a different variety of reasons. They may be afraid of potential dependency feelings, expect "exhortative lectures" from the doctor, or fear that the doctor will discover a serious mental illness or that they will be stigmatized by their peers.

Special circumstances—to us, the only ones —that seem to warrant seeing a child younger than fifteen or sixteen prior to the consultative visit with his parents, are represented by the situation in which the youngster's wish has initiated the referral to a psychiatrist. Here we would try to respond to this mature attempt to get help by seeing the youngster first. Indeed, we sometimes try to structure this attitude in the older adolescent; that is, we suggest to the calling parent that his son or daughter should call for a first appointment so that it can be arranged without the parent as intermediary. Our justification for this, or for actually seeing the youngster before the parents, is to indicate our respect for the youngster and his opinions and to lend support to his sense of self and autonomous responsibility. But this should not be an empty gesture, whether in terms of the psychiatrist's attitude, the realities of the situation, or the youngster's capacity to respond to such an overture.

Much has been written in recent years about the need of the psychiatrist to ally himself with his adolescent patient and have as little to do with the parents as possible. We feel this has sometimes been carried to extremes.

Parents should be seen at least once or twice in the evaluation phase, and they deserve a summary discussion of the assessment and recommendations. This may take place with or without the designated patient being present. We find also that it prevents a lot of disruption if the parents are seen once or twice in the early weeks of treatment, when someone other than the therapist has done the evaluation. We think they have a right to see the person to whom they have entrusted their youngster's treatment. At the same time these visits give the psychiatrist a chance to form a mental image of the parents, to be placed alongside the image the adolescent is creating for him.

The adolescent who is attending college or is working to support himself, whether away from home or not, is more appropriately dealt with as an autonomous person who is responsible for his own financial and other arrangements. Problems arise when the youngster has not yet reached his majority; in fact the legal questions involved here, as previously noted, have recently been in flux.

Long-Term Psychotherapy: General Considerations

Psychotherapy has often been likened to chess. Certainly one can speak of "opening moves," with their potential problems and strategies, and of the "closing" or termination phase. Things are much less clear when we turn to the phase of the "middle game." Here the possibilities are far more varied and

reflect what is unique and idiosyncratic to the particular patient. This chess-like, three-phase division is particularly true of long-term treatment or crisis intervention, even though in reality these boundaries between phases will blur and overlap.

Whatever the age of the child patient, there is one essential to all successful psychotherapy: it must be interesting to the youngster himself. Many children would find it impossible to explain what goes on in treatment to an outsider or even to their parents; they only "know" that something good is happening. If therapy becomes dry and dull, it can become self-defeating. Conversely, one must guard against its becoming overly exciting, stimulating, or seductive, since this too can drive the patient away. As alluded to earlier, resistance can sometimes take the form of making the treatment hours dull and uninteresting. This seems to happen most often with the young adolescent who must defend himself from getting overly involved with an adult. At the same time, if the physician is to keep the youngster's interests and gain his respect, he must be ready to recast some of his thinking about the therapist's role. For example: to be too flat, too quiet, too unemotional, too much the "psychoanalytic screen" can be deadly in work with children or adolescents. (It can, in fact, be just as deadly for adults, but fortunately they are somewhat more tolerant.)

Treatment proper begins after the evaluation of the youngster and his

family is completed and the recommendation for treatment has been made and accepted (Brody, 1964; Haworth, 1964; Keith, 1968; Sylvester, 1966). The acceptance will have different meanings for different family members and will in any case be ambivalent. Some older children may be quite reluctant and will unconsciously test the parents' convictions that change can indeed occur. Others will be resistant for reasons that can often be dealt with during a trial period that is labeled as such. But care must be taken that the patient does not take this "trial" as permission simply to "hold out for the duration" and never let himself be engaged.

There is no doubt that the young adolescent can render all treatment efforts impotent. But it is also surprising how often the angry, blustering youngster continues to show up for his sessions even when no parent has brought him. It is unwise to interpret this attitude too early, because it will threaten the youngster's defense and have the effect of forcing him into leaving. The better course is to acknowledge to the youngster how hard it is for him to do things that others—most of all, perhaps, his parents—demand of him. One can suggest that he may want to make the best of it and find something interesting and useful for himself in the therapeutic process. Here the physician attempts to divert the transference from aligning the therapist with the parents, since for such an adolescent the strong concern may be that the therapist wants mainly to change him into the kind of person his parents would want him to be. As an adult, the therapist has to convince him instead

that he is a potential ally and able to help the adolescent achieve his own goals. Often these goals turn out to be quite close to what his parents also would want: doing well in school, planning for college, having friends, being social, holding a job, and so on.

Opening Moves

All initial moves in psychotherapy, whether with child or adolescent, are part of the process of getting acquainted. Keeping in mind the youngster's developmental capacities or stage, the therapist tries to create a nonthreatening climate in which two people can try to get to know each other better in a unique situation. By being as open and direct with a given patient as that youngster can tolerate, the therapist is sending a unique and perhaps unusual message: most youngsters have had no experience with doctors except for physical illness, and the concept of a "talking doctor" or "worry doctor" may find them somewhat skeptical. From television they may have come to think of psychiatrists as "mind readers," as working miraculous transformations, or as having other fanciful skills. It is very possible that heretofore most of the adults in the child's life have tended to tell him what he could do and what he could not do, what was good and what was bad, and what things he would be punished for doing. Thus he is initially mystified to find a strange and different type of doctor and adult—one who seems only to want to get to know him better, and on the youngster's own terms. In

addition, this adult seems oddly interested in things such as what the child felt when something happened or what he thought about a given event. It is these qualities of thoughtfulness, interest, and insightfulness that the child gets to know in the initial process: a nonjudgmental stance that does not ignore potential consequences of action but lays equal stress on an awareness of feeling states.

In this process of getting acquainted, the child will gradually reveal to the therapist bits and pieces of his life and his interests (or lack of interests). It is a period of experimentation in which the child will be testing his concerns and preoccupations with this unusual adult. Will the therapist after all be like all other adults he has known? Is this adult's interest and attentiveness going to end up badly, as it has with others? Gradually he reveals more of his private world of thoughts and fantasies, his worries, his fears, and other important feelings. In the case of the younger child, who in many ways takes new "goodies" for granted, the provision of play materials may claim his immediate attention. Others are inhibited and may need the physician's encouragement to reach out for them. With the older youngster, one may want to explain that this talk and play is not just for fun alone but also for the clues that it can yield about the patient's worries and behavior. For the young adolescent this may be an awkward time, and the therapist may have to acknowledge this fact. He may also need to be somewhat active and participate more.

The opening phase of treatment allows the child, unconsciously, to chart the course of the treatment. Much can be learned from how he handles these early interviews—what he brings up and what he leaves out. Often the most revealing thing is not the manifest content so much as what is latent within it; a comparable situation is the first dream an adult may report in psychotherapy. Comments from the therapist in these opening hours are mostly inquiries for clarification, expressions of interest or curiosity, and, if necessary, the acknowledgement of some difficulty the youngster is experiencing. The therapist tries to convey his benign, adult interest without intrusiveness. He shows patience without compliance, empathy without identification, and, finally, his belief that he can be helpful without being overwhelming.

After a time a youngster may become aware that this "getting acquainted" is not exactly what he expected, but by then the therapy has entered the middle phase. What has probably struck him is that he knows little of the therapist's private life, and he may come to feel he was slighted or tricked into revealing himself. This is especially true of young and middle adolescents, who may feel "put down" or manipulated by what they perceive as an unjustly unequal relationship. Usually these accusations are signs of the adolescent's sudden, unconscious awareness of vulnerability and constitute a defensive maneuver—that is, "the best defense is an offense." Depending on when this maneuver appears in the course of treatment, and it may appear

many times, one can deal with it factually. It is a technique well-suited to helping people with their troubles. Start to interpret the defense; "Something just happened in your thoughts that made you feel the relationship is unfair;" or explore the transference: "This feeling of being 'tricked' or 'put down' is something you often feel with people." To give a little information is also not harmful and, surprisingly, can be quite helpful, even if nonspecific—as, for example, saying that one is going to Europe this summer, or that one's summer house is in the Upper Peninsula of Michigan.

Middle Phase

To generalize about the so-called middle phase of treatment is risky at best, because so much depends on the individual therapist who is working with a particular child who presents a certain picture of pathology and strengths. This is the period in which the therapist must rely the most on his own initiative, imagination, and skills. In the literature, this is the period of treatment that is usually condensed in the case presentation and sounds planful and orderly, and in retrospect it may indeed be simple enough to classify the work into periods or stages. But in the heat of the actual process these stages are not always easy to recognize, since this is a fluid period. Themes may occur and appear to be resolved, only to occur again, perhaps with variations. Sometimes one gets the feeling of whittling away at or gradually peeling back the elements of the problem. "Working through," a

term hard to define, has been used to describe much of what happens in the middle phase of treatment. On another level, there may also be periods during this middle phase when the therapist is excited by capacities that the child suddenly exhibits for communicating and integrating insights. And there may be periods when he grows discouraged by a plateau the child has reached, and by a resistance that seems impenetrable.

The length of this middle stage may sometimes be dictated by external events or circumstances. There may be a move out of town by the therapist or the patient and his family, some member of the family may develop a chronic illness, and so forth. But whatever the cause, this middle stage is brought to a close when either the parents or the therapist announce the necessity for termination. Of all the physician's reasons for this move, the most desirable, of course, is that the therapeutic goals have been achieved and that the child has improved to the point where therapy can be called successful. In other cases, some gains will have been made while other goals remain to be achieved, and yet further therapeutic work is not possible—perhaps for financial reasons, or because the child has grown so heavily involved in school work or peer activities that it becomes more appropriate to stop treatment even though not all respective goals have been realized. Finally, the therapist may have had only limited goals in mind, and calls for an end to therapy because he feels he has accomplished as much as he could.

Terminal Phase

The last phase of treatment begins when the question of termination has been seriously raised and affirmatively answered. While parents or child may speak of termination themselves, this is technically considered a resistance problem until the therapist himself is convinced. It is then his prerogative and duty to suggest ending psychotherapy. Whether he raises it first with the child or the parents will depend on the age of the child. Each will have feelings about it that must be allowed expression and dealt with. This may also be a very natural time to review with the patient what has been talked about, events that have taken place, what the youngster was like when treatment began, and what he is like at this point. Everyone, parents included, can now look at the overall situation, past, present, and even future. Stimulated by such a review and by the prospect that the era of therapeutic help will be ending, one can expect some resurgence of original symptoms in the child. Often parents and/or child, as well as therapist, are made anxious by this and begin to doubt the correctness of the decision. But usually the recurrence of symptoms is transient and is worked through fairly rapidly. Since much of child psychopathology is rooted in issues of separation, none of this should be surprising. Indeed, this work can be thought of as a consolidation of gains and a working through of separation anxieties and residual fears about the return of symptoms.

One important aspect of termination that is often overlooked or minimized is the nature of the separation anxieties and discomforts that are stimulated by approaching termination. The therapist who minimizes the difficulty of termination or delays announcing it is expressing, through countertransference, his own emotional difficulty in disengaging himself from patient and family. If the therapist has been reasonably successful, the youngster has had a rich and valuable experience and formed a unique relationship. The therapist, for his part, has had an enriching and gratifying experience and a relationship that has claimed much of his thought and attention. Both will experience some pain at separation. It is an essential, concluding, and integrating experience and must be worked out either in metaphor, in play, or in direct communication, because it is a basic ingredient of the human experience.

With the older child and adolescent, there is great value in stressing that problems are inevitable and will continue to arise in the course of his life. But the therapist must also express confidence in the youngster's ability to cope with them in the future, emphasizing that it is his coping capacity that has grown in the course of therapy and not that he will encounter no further problems.

It takes time to work through what took place and what was accomplished in the course of treatment. It also takes time to work through

the painful ending of a mutually valued relationship, how much time, it is difficult to say; but more often than not, one tends to underestimate it. Even young children need time, though they may have no clear time concept as yet. It helps to make them a calendar on which they can keep track of how many appointment hours remain until the last one. Selecting a date that falls right before a well-known holiday or the ending of school is another way of helping them. Older children who can manage time quite well may suddenly have trouble remembering when the last appointment will be, or will proceed as if nothing unusual lies ahead. They will have to be gently confronted with such avoidance of a painful topic, though the child may not directly acknowledge it until the last hour.

Short-Term Treatment

In general, treatment that is three to fifty sessions in duration is regarded in the literature as "short term," and it has been variously defined and recommended (Barton, 1973; Berlin, 1970; Proskauer, 1969; Proskauer, 1971). For example, some consider it appropriate therapy only for acute reactive problems, while others see it as being used to make circumscribed contributions to severely troubled youngsters. A third group of writers view time-limited treatment as being focused by the presence of crisis; the therapeutic work is then regarded as growth through crisis resolution. It is our opinion that, for the very young child expressing distress, a short

intervention may be very useful in helping mother and child realign their relationship before it has become entrenched. Here the relative plasticity of the child's psychic structure allows rapid change to occur. Similarly, for the adolescent who often experiences intense worries and preoccupations and who tends to view all problems as crises, a short and skillful intervention can be very helpful. Here, too, the psychic agencies, although more complex than the young child's, are less rigidly fixed than the latency-age or adult psyche and therefore more amenable to short interventions.

It would be gratifying to assert that the decision to undertake short- (rather than long-) term therapy is dictated solely or at least primarily by clinical considerations. But in reality, the duration of treatment is more often determined by time availability. Often a clinic must serve many patients, and thus a short, specifically focused bit of therapeutic work is the most that can be offered. Or perhaps a trainee has a relatively short, finite period of time to work with a case. Sometimes a family lives so far from the treatment center that prolonged treatment is impractical. We mention such factors not as criticisms but rather as reality parameters that the therapist must recognize and resolve. If he does not come to terms with them, he runs the risk of attempting more than he can actually hope to achieve. To put it simplistically, when the time is short—for whatever reason—then short-term treatment is in order, and realistic goals must be set for all persons involved.

Effective short-term therapy may well be the most difficult of the psychotherapies, since there is little leeway for error or change in therapeutic direction. The starting phase of treatment must be quickly accomplished and depends on accurate and confident appraisal of the young person's psychopathology, psychic strengths, and actual environment (that is, his home/school situation). The therapist must have a good knowledge of the way the youngster of a particular age perceives, thinks, and fantasizes, and of the modes in which he can communicate his concerns and worries. The therapist must be able to be active without giving wild interpretations, be ego- rather than id-oriented, and be selective in what he comments upon and how. He must feel comfortable with limited goals and see them as valid contributions to a youngster's mental health. Finally, it should go without saying, that the special conditions of short-term treatment also apply to and affect the nature of the work with the parents.

The primary characteristics of short-term psychotherapy, then, are goal-directedness, the defining of an arena of work that serves to focus the therapist's thought and comments, and a finite time limit that is known by all concerned when treatment begins. There are several derivative requirements: (1) The youngster must have the capacity and the willingness to relate rather quickly to the therapist, who in turn must possess the reciprocal capacity. (2) The therapist must be able to determine, from the historical material and his first interview with the youngster, what the

focusing should be. (3) Termination must be recognized as a topic with which one must deal. In some cases where object loss has played an important role in the pathology, this may itself prove to be the focus. If, however, self-esteem for example, is the focus, termination may appear as proof of "I'm not worthy," which must then be worked through. (4) Particular care must be taken to direct interpretations to the focal arena. (5) Comments on material should be directed "upward" to ego capacities and affects rather than "downward" to id impulses. One does not want to arouse defenses but rather to increase the capacity to cope, and the courage to use this capacity.

The difference between short- and longterm therapy might best be illustrated by an analogy. The novel and the short story have many characteristics in common. When skillfully done, different effects are achieved, and it would be incorrect to assert that either one is "better." Only in terms of what is being attempted can one assess the form. The same is true in the choice of therapies. Does the technique match the goal? Does the goal match the needs of the patient?

Concluding Remarks

We have attempted to provide an outline of psychotherapy with children and adolescents that is based primarily on a developmental and psychodynamic understanding of psychopathology. We have discussed

qualities that we feel are essential for a child therapist, and delineated at least some of the mental processes that go on while doing such work. The primary arena of play has been explored. The role of parents has been discussed, including the frequent problem of patient confidentiality. Common technical problems have been related to developmental levels, on the one hand, and to the opening, middle, and terminating phases of psychotherapy on the other. Finally, we have attempted to differentiate long-term psychotherapy from short-term treatment on the basis of what the therapist intends to do with material gleaned from the history of the youngster and observation of his play and talk. Our bibliography has been in large measure selected with the intention of making available to the reader further knowledge about the many aspects of psychotherapy with children and adolescents that have been touched upon here, but only briefly.

Bibliography

Aichorn, A. *Wayward Youth*. New York: Viking, 1935.

---. *Delinquency and Child Guidance: Selected Papers*. New York: International Universities Press, 1964.

Allen, F. H. *Psychotherapy with Children*. New York: Norton, 1942.

American Society for Adolescent Psychiatry. "Position Statement on Training in Adolescent Psychiatry," in S. L. Feinstein, P. L. Giovacchini, and A. A. Miller, eds., *Adolescent Psychiatry*, Vol. 1, pp. 418-424. New York: Basic Books, 1971.

- Anthony, E. J. and T. Benedek, eds. *Parenthood: Its Psychology and Pathology*. Boston: Little, Brown, 1970.
- Axline, V. M. *Play Therapy*. Boston: Houghton Mifflin, 1947.
- Bardwick, J. M. *Psychology of Women*. New York: Harper & Row, 1971.
- Barton, M. and S. S. Barten. *Children and Their Parents in Brief Therapy*. New York: Behavioral Pubs., 1973.
- Berlin, I. N. "Crisis Intervention and Short Term Therapy: An Approach in a Child Psychiatric Clinic," *J. Am. Acad. Child Psychiatry*, 9 (1970), 595-606.
- Blom, C. "A Psychoanalytic Viewpoint of Behavior Modification in Clinical and Educational Settings," *J. Am. Acad. Child Psychiatry*, 11 (1972), 675-693.
- Blos, P., Jr. "Silence: A Clinical Exploration," *Psychoanal. Q.*, 41 (1972), 348-363.
- Blos, P., Sn. *On Adolescence: A Psychoanalytic Interpretation*. New York: Free Press, 1962.
- . *The Young Adolescent: Clinical Studies*. New York: Free Press, 1970.
- Brody, S. "Aims and Methods in Child Psychotherapy," *J. Am. Acad. Child Psychiatry*, 3 (1964). 385-412.
- Chess, S., A. Thomas, and H. G. Birch. *Temperament and Behavior Disorders*. New York: Brunner/Mazel, 1968.
- Erikson, E. H. "Studies in the Interpretation of Play: 1. Clinical Observation of Play Construction in Young Children," *Genet. Psychol. Monogr.*, 22 (1940). 557-671.
- . "Sex Differences in the Play Configurations in Pre-Adolescents," *Am. J. Orthopsychiatry*, 21 (1951), 667-692.
- . "Identity and the Life Cycle," in *Psychol. Issues*, Vol. 1, no. 1. New York: International Universities Press, 1959.

----. (1950) *Childhood and Society*, 2nd ed. New York: Norton, 1963.

----. *Identity: Youth and Crisis*. New York: Norton, 1969.

Feinstein, S. C., P. L. Giovacchini, and A. A. Miller, eds. *Adolescent Psychiatry*. Vol. 1, *Developmental and Clinical Studies*. New York: Basic Books, 1971.

Finch, S. and H. Burks. "Early Psychotherapeutic Management of the School Phobia," *Postgrad. Med.*, 27 (1960), 140-147.

Flavell, J. H. *The Developmental Psychology of Jean Piaget*. Princeton: Van Nostrand Reinhold, 1963.

Freud, A. (1936-1937) *The Ego and the Mechanisms of Defense*. New York: International Universities Press, 1946.

----. *The Psychoanalytical Treatment of Children*. Translated by N. Procter-Gregg. London: Imago, 1946.

----. *Normality and Pathology in Childhood*. New York: International Universities Press, 1965.

Freud, S. (1905) "Three Essays on the Theory of Sexuality," in J. Strachey, ed., *Standard Edition*, Vol. 7, pp. 123-243. London: Hogarth, 1953.

----. (1909) "Analysis of a Phobia in a Five-Year-Old Boy," in J. Strachey, ed., *Standard Edition*, Vol. 10, pp. 5-147. London: Hogarth, 1955.

----. (1922) "Postscript to the 'Analysis of a Phobia in a Five-Year-Old Boy'," in J. Strachey, ed., *Standard Edition*, Vol. 10, pp. 148-149. London: Hogarth, 1955.

----. (1923) "The Ego and the Id," in J. Strachey, ed., *Standard Edition*, Vol. 19, pp. 1-66. London: Hogarth, 1961.

----. (1926) "Inhibitions, Symptoms and Anxiety," in J. Strachey, ed., *Standard Edition*, Vol. 20, pp. 77-175. London: Hogarth, 1959.

- Gesell, A. L. and C. S. Amatruda. *Developmental Diagnosis: Normal and Abnormal Child Development*. New York: Hoeber, 1941-
- Hall, G. S. *Adolescence*, Vols. 1-2. New York: Appleton, 1907.
- Halpern, H. M. *A Parent's Guide to Child Psychotherapy*. New York: A. S. Barnes, 1963.
- Hartmann, H. *Ego Psychology and the Problem of Adaptation*. New York: International Universities Press, 1958.
- . *Essays on Ego Psychology*. New York: International Universities Press, 1964.
- Haworth, M. R., ed. *Child Psychotherapy: Practice and Theory*. New York: Basic Books, 1964.
- Haworth, M. R. and M. J. Keller. "The Use of Food in the Diagnosis and Therapy of Emotionally Disturbed Children," *J. Am. Acad. Child Psychiatry*, 1 (1962), 548- 563.
- Itard, J. M. (1801) *The Wild Boy of Aveyron*. Translated by G. Humphrey and M. Humphrey. New York: Appleton-Century-Crofts, 1962.
- Johnson, A. M., E. I. Falstein, S. A. Szurek et al. "School Phobia," *Am. J. Orthopsychiatry*, 11 (1941), 702-711.
- Keith, C. R. "The Therapeutic Alliance in Child Psychotherapy," *J. Am. Acad. of Child Psychiatry*, 7 (1968), 31-43.
- Kessler, J. W. *Psychopathology of Childhood*. Englewood Cliffs, N.J.: Prentice- Hall, 1966.
- Kiell, N. *The Universal Experience of Adolescence*. New York: International Universities Press, 1964.
- Levin, S. and H. Wermer. "The Significance of Giving Gifts to Children in Therapy," *J. Am. Acad. Child Psychiatry*, 5 (1966), 630-652.
- Loomis, E. A., Jr. "The Use of Checkers in Handling Certain Resistances in Child Therapy and Child Analysis," *J. Am. Psychoanal. Assoc.*, 5 (1957), 130-135.

- McDonald, M. "The Psychiatric Evaluation of Children," *J. Am. Acad. Child Psychiatry*, 4 (1965), 569-612.
- Malmquist, C. "School Phobia: A Problem in Family Neurosis," *J. Am. Acad. Child Psychiatry*, 4 (1965), 293-319.
- Meeks, J. E. "Children Who Cheat at Games," *J. Am. Acad. Child Psychiatry*, 9 (1970), 157-170.
- Millar, T. P. "Home-School Communication Concerning Non-adjusting Children," *J. Am. Acad. Child Psychiatry*, 4 (1965), 320-329.
- Newman, M. B. and M. San Martino. "The Child and the Seriously Disturbed Parent: Treatment Issues," *J. Am. Acad. Child Psychiatry*, 12 (1973), 162-181.
- Piaget, J. and B. Inhelder. *The Psychology of the Child*. New York: Basic Books, 1969.
- Proskauer, S. "Some Technical Issues in Time-Limited Psychotherapy with Children," *J. Am. Acad. Child Psychiatry*, 8 (1969), 154-169.
- . "Focused Time-Limited Psychotherapy with Children," *J. Am. Acad. Child Psychiatry*, 10 (1971), 619-639.
- Ritvo, S., A. T. McCollum, E. Omwabe et al. "Some Relations of Constitution, Environment, and Personality as Observed in a Longitudinal Study of Child Development: Case Report," in A. Solnit and S. Province, eds., *Modern Perspectives in Child Development*, pp. 107-161. New York: International Universities Press, 1963.
- Ross, A. O. "Confidentiality in Child Guidance Treatment," *Ment. Hyg.*, 42 (1958), 60-66.
- Silberstein, R. M. and H. Irwin. "Jean-Marc-Gaspard Itard and The Savage of Aveyron: An Unsolved Diagnostic Problem in Child Psychiatry," *J. Am. Acad. Child Psychiatry*, 1 (1962), 314-322.
- Skurow, N. R. and I. M. Dizenhuz. "Teaching about Teaching: A Program Sensitizing Child Psychiatry Fellows to Schools," *J. Am. Acad. Child Psychiatry*, 12 (1973), 354-365.

- Stone, L. J. and J. Church. *Childhood and Adolescence*, 2nd ed. New York: Random House, 1968.
- Sylvester, E. and S. Cooper. "Truisms and Slogans in the Practice of Teaching Child Psychotherapy," *J. Am. Acad. Child Psychiatry*, 5 (1966), 617-629.
- Taft, J. *The Dynamics of Therapy in a Controlled Relationship*. New York- Macmillan, 1933.
- Tanner, J. M. *Growth At Adolescence*, 2nd ed. Springfield, Ill.: Charles C. Thomas, 1962.
- . "Sequence, Tempo, and Individual Variation in Growth and Development of Boys and Girls Age 12 to 16," in J. Kagan and R. Coles, eds., *12 to 16: Early Adolescence*, pp. 1-24. New York: Norton, 1972.
- Waldfugel, S., J. C. Coolidge, and P. Hahn. "The Development, Meaning and Management of School Phobia," *Am. J. Orthopsychiatry*, 27 (1957), 754-780.
- Westman, J., ed. *Individual Differences in Children*. New York: Wiley, 1973.
- Wolff, P. H. *The Developmental Psychologies of Jean Piaget and Psychoanalysis*. Psychol. Issues Monograph no. 5. New York: International Universities Press, 1960.