

*American Handbook of Psychiatry*

# **CHILD THERAPY TECHNIQUES**

**E. James Anthony**

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# CHILD THERAPY TECHNIQUES

The emergence of the child as a treatable patient was accomplished over a protracted period of time and through a succession of stages. First came the recognition of the child as a child; in his illuminating biography of the child through the ages, Aries pointed out that the social identity subsumed under the term “child” was of comparatively recent origin and that for many centuries of Western culture children were regarded as incomplete adults. It was not until the early seventeenth century that childhood was accorded a special status in its own right. The recognition of the child as emotionally disturbed, as opposed to brain damaged or mentally defective, came much later and can be considered partly a twentieth-century phenomenon. However, it was not until Freud’s 1909 detailed clinical description of a phobia in a five-year-old boy that the intangibles of neurosis were separated from willfulness and naughtiness. With characteristic boldness, he declared that problems of this kind in childhood were “quite extraordinarily frequent” but were generally “shouted down in the nursery.” With equal audacity he suggested that children suffering from such conditions were treatable in the same sense that adults were treatable, and he then proceeded to the first successful treatment of a neurotic child.

This recognition of psychological disturbance in the child and its treatability obtained further elaboration over the next few decades as the

scope of diagnosis and treatment was widened. The concept of the child as an individual gave place to that of the child as a whole within a total environment. This at once added several new dimensions to the picture, taking into account the interactions of mind and body, the conscious and unconscious determinants of his behavior, the influences emanating from his family, as well as the effects of class, culture, and environment. With each additional facet the responsibility for the disturbance was increasingly shared with the parents, the family, the neighborhood, and even society, which led to some diffuseness of the therapeutic aim. At the same time, this expansive movement was counteracted by another that set limits to treatability. The potential for this came to be assessed predominantly in terms of suitability for psychotherapy, and it soon transpired that therapist and patient, more often than not, came from the same exclusive neighborhood and shared the same cultural advantages, such as verbal fluency, testable intelligence, and the capacity for abstract thinking.

The portrait of the child as a patient, however, had still to be completed since the important dimension of time had been omitted from previous accounts. He was now seen as developing through a sequence of stages, each of which might influence the nature and outcome of his disturbance. His status, in the general life cycle of the individual, was now assured; from being the incomplete man, he had become the father to the man, and his treatment assumed preventive significance.

In all this development the child had ceased to be a passive victim of circumstance and was considered not only an active agent in the setting up of his own disturbance but an instigator of disturbance in others in his immediate environment. As a patient, he was susceptible to as wide a spectrum of disturbances as those affecting adults, matching most of their diagnoses and adding several peculiar to himself. To the variety of diagnoses, a variety of treatments have been added, indicating a new need for careful and more specific prescription and treatment planning.

In its most recent evolution the overemphasis on pathology has been corrected by the further consideration of psychological assets, such as natural endowment, constitutional resilience, and the capacity to cope with anxiety, frustration, novelty, and other stresses. The assessment of the child as a patient now needed to include an inventory of his potentials as a person and as a patient.

### **Pioneers of Child Therapy Techniques**

The emergence of the child as a patient had its correlates in the emergence of the child therapist and his techniques. The first systematic piece of child therapy was carried out by a father on his son under the supervision of Freud, and although the treatment could be regarded as highly successful both at termination and subsequent follow up, this particular

treatment model has not stimulated too many imitators. In fact, fathers have proved notoriously difficult to involve in the therapy of a child. In the follow-up evaluation, some seventeen years after the treatment, the above mentioned child patient met all the requirements for a cure. He was perfectly well and free from troubles and inhibitions, and his emotional life had successfully undergone the severest of ordeals, the divorce of his parents and the consequent separation from his much loved sister. There had been no detrimental consequences as a result of opening up his unconscious mind, and the uncovered events, together with the therapy, had both been “overtaken by amnesia.” He had also traversed the pitfalls of puberty without damage. At this point in history it was not sufficient to demonstrate that child therapy did good; it was also necessary to show that it did no harm, and Freud’s case was a double success from this point of view.

### **Child Therapy and the Delinquent**

The treatment of the phobic child proved a stimulus to the field. The next step was taken by Healy, who synthesized the relevant and burgeoning knowledge in this area and fashioned it into a therapeutic instrument that provided the basis for the child guidance approach of study and treatment by an interdisciplinary team. In Healy’s clinic, the child, together with his family, was confronted by a group of experts who carefully assessed both internal and external realities in terms of past and present experiences. For the first

time in clinical history the child was invited to tell his own story in his own way and in his own time, a truly radical departure from being peremptorily dosed and discharged. Although the child's problems were considered within the framework of a dynamic, developmental psychopathology, its antisocial nature demanded extensive manipulations of the environment, meaning active social work. Within the analytic context, the concept of environment itself underwent change and came to be viewed as "fluid, intimate—composed of living, changing, reacting personalities." Shifts in the external environment, however dynamically conceived, were not sufficient in themselves to alter the delinquent tendency, and, as its etiology was traced to the earliest deprivations and disadvantages, the need to establish a working therapeutic alliance with the delinquent patient was seen to be fundamental. A special kind of therapist, with an inordinate capacity for tolerating antisocial behavior, undertook the job of rendering the patient treatable by establishing a relationship and subsequently neuroticizing the problem. Unlike the phobic child treated by Freud, this type of patient required preparatory treatment before he was able to tolerate an uncovering or probing therapy.

### **The Development of Child Analysis**

Psychoanalysis as a specific technique made comparatively little contribution to child therapy until the development of child analysis during

the second and third decades of this century. This was associated with the discovery of play as a major mode of communication and expression for the child in treatment. As early as 1924, Abraham remarked that the future of psychoanalysis itself lay in the play analysis of children, and that he looked to it for future theoretical developments. The work of the child analysts Melanie Klein and Anna Freud, during the subsequent period, testified to the truth of this prediction. Klein developed a new metapsychology on the basis of her child analytic work, and further, her experience convinced her that children were analyzable to the same extent as adults and that one could even go “deeper” with them. Children, she felt, developed a transference neurosis similar to that in the adult patient and were technically treatable from the second year onward. Anna Freud had many reservations in the beginning regarding the child’s potential for analysis, and, at an earlier phase, limited its application to children of latency age whose parents had themselves undergone analysis. In place of the direct symbolic interpretation of Klein she substituted a more cautious analysis of resistance, and whereas Klein made use of play as free association, Anna Freud tended to regard it as one of several important ways of learning about the child from the child. At this earlier time she was impressed by the limitations of the child as an analytic patient. The differences from the adult counterpart seemed to her then striking: The child did not come for treatment but was brought; it was not he who complained but his parents; he was unable to lie on a couch, free

associate, analyze his dreams, work through his resistances, or develop a transference neurosis. All this meant that he was not analyzable in the classical meaning of the term but only in an applied sense. In recent years, Anna Freud has veered around to Klein's position. She regards many more children as analyzable and recognizes the development of transference neurosis in some children. Whereas she began her work in analytically oriented psychotherapy, she is now training her students in child analysis.

### **Nondirective Psychotherapy**

According to Carl Rogers there is a powerful creative force within every individual that strives continually for self-realization, independence, maturity, and self-determination, and, if given an opportunity to act, it can work out a constructive adjustment to even the most difficult realities confronting the person. It is the therapist's role to release this curative element by providing the growing ground for its development. He may accomplish this simply by giving tacit permission to the individual to be accepted by himself and others. Once self-confidence has been established, the rest can be left to the growth impulse, the operation of which will make mature behavior preferable to immature behavior. The patient assumes direction and responsibility for his own treatment since the cure resides within him. Axline adapted the Rogerian technique to child therapy, applying the same principles both to individual and group situations. There is an

inspirational quality about this approach that, together with its somewhat reverential attitude toward the child, its positivistic philosophy, its insistent high-mindedness, and its simplistic theoretical structure, has turned away the average secular therapist. The idea that spontaneous expression of itself is the key to therapeutic change takes little account of the complex system of defenses set up in the disturbed individual as well as the variety of reaction patterns brought into play by different life experiences and constitutions. It is, therefore, not surprising that Axline disdained the diagnostic evaluation and believed that “regardless of symptomatic behavior, the individual is met by the therapist *where* he is.”

A number of similar therapies have also stemmed from the work of Otto Rank and Alfred Adler, all having in common an emphasis on the living relationship and a primary focus of the patient. The so-called client-centered therapy also views the relationship as a significant growth experience but treats the therapist and child as separate individuals, the role of the therapist being to reflect, clarify, and demonstrate an empathic understanding of his client’s predicament.

Allen, deriving his therapeutic stance from Rank, put special stress on the here and now. The relationship is “an immediate experience,” and therapeutic reality exists in the present not in the “past present.” The therapist himself is “a living symbol of the present world” and must maintain

his own realness and not retreat through transference into the dark recesses of the past. The therapeutic setting is in essence an encounter with a world of pressing realities. The past holds a measure of safety, and it is in the present that the anxieties and insecurities lie. The therapist is not there to change the patient but to help the patient to change himself. His skill and training have no therapeutic value unless they are used by the patient. It is what the child does spontaneously on his own and in his own way, without prompting or coercion, that helps to induce the change. Immediacy, spontaneity, creativity, and uniqueness make up the prime components of this unusual encounter. Psychotherapy in this sense is not a rite or a ritual but a realization. The encounter movement in its present form has turned even further away from intellectual understanding and has made spontaneous affective experience the critical dynamic factor in treatment.

### **Release Therapy**

Classical catharsis was given a new lease on life when Levy formulated his technique of release therapy, which he felt was appropriate for uncomplicated problems in family relationships of recent onset and of short duration in children under the age of ten years, where a definite symptom picture had been precipitated by some disturbing specific event, such as birth, divorce, death, or frightening experience. Levy described three types of situations in which the technique appeared to work effectively: (1) where

there is a simple release of inhibited aggressive or infantile regressive behavior by means of acting out such behaviors in a permissive setting; (2) where there is a release of feeling in a standardized provocative situation in which, for example, two sibling dolls compete for a mother, or a nude doll demonstrates sex differences, or two parent dolls are brought together in a primal scene; and (3) where there is a release of feelings in a specific play situation set up to resemble the recent traumatic experience in the life of the patient. In this third situation, the therapist acts "like a friendly property man" who selects the props, sets the stage, and depicts the plot, occasionally acting as prompter. The acting-out principle assumed to function in this situation could be compared to a dilation process designed to stretch a somewhat constricted personality. The result can at times be tempestuous, and Levy warned that a cardinal rule of the situation should be that the therapist be spared. He is likely to get involved when transference is activated, and when this happens, of course, the treatment proceeds beyond the limits of release therapy. This particular technique can be best regarded as crisis intervention and therefore limited to particular situations. Levy's suggestion that it might be used as a prelude to insight therapy or as an interlude in a resistant psychotherapy would not be accepted by analytically oriented psychotherapists today. Such shock procedures create many more problems than they solve and can interfere seriously with the careful and systematic work of psychotherapy. As Allen pointed out, "The mere release or

getting out of feeling has little value therapeutically. It is the incorporation of that feeling into himself and the ability to be responsible for its use and direction that constitutes growth.”

### **Suppressive Therapy**

At the opposite pole from release therapy is suppressive therapy, proposed by Escalona for children showing extreme weakness in ego functioning and at times a disintegrative dependency that interferes profoundly with ego development. In such cases, the children have failed to repress the psychic experiences that normally should be unconscious; their spontaneous verbalization of conscious content resembles the dreams of other children, and their play during the initial interviews is like the play of neurotic children who have been in therapy for some time. Thus the therapy is directed at discouraging the expression and acting out of fantasies, and at providing many opportunities for realistic activities together with the strengthening of reality testing. Whether suppressive therapy could work in practice is still a moot point since the procedure has not been systematically studied in a large enough number of children. It does suggest, however, the possibility that expressive types of psychotherapy in some cases may tend to operate in antitherapeutic ways to the detriment of the child's condition.

### **Projection Therapy**

Projection therapy is merely an example of the way in which therapists, somewhat grandiosely, attach labels to some particular medium by which communication with the child is channeled. Play therapy, in which the child is given a free choice in the use of small toys and freedom in the way in which they are to be used, is a particular example of such a tendency. Differences exist in the extent to which the therapist participates or makes interpretations. The assumption is that the child will endeavor to play out his problems if given this opportunity. There is still much difference of opinion as to whether play is a medium of therapy or therapeutic in itself. All the great dynamic therapists were directly or indirectly alive to the endless theoretical issues latent in the play of children. For Freud the interest lay in its creativity, and he compared the child at play to an imaginative writer creating a world of his own or rearranging his world to please himself. He was aware of the essential seriousness of play for the child. Jung was equally aware of its seriousness for the adult and described how even into old age he was often able to deal successfully with his anxieties by resorting to play. For Erikson, the play situation was a human laboratory in which the child experimented with reality by creating model situations in which he relived the past, redeemed his present failures, and anticipated the future. Ever since Freud, child therapists have been aware that the child will play compulsively and repetitively in order to master inner and outer traumatic anxieties, especially if he is able to reverse the roles and become the master and not the victim of

the experience. All these elements of creative problem-solving, catharsis, repetition compulsion, tension reduction, wish fulfillment, vacation from reality, and passivity into activity have been built up into a comprehensive psychoanalytic theory of play that, in turn, could be appropriately applied to the therapeutic situation. The possibilities for the child in this miniature world are so varied that it is not surprising that he visits it so frequently in the service of self-therapy. In his make believe he can animate a lifeless object, invent an imaginary companion, identify with a fearsome character, vent his hostility without reprisal, exercise his primitive magic, test out limits, and investigate solutions to his conflicts. Under the eye of the therapist the therapeutic elements of play can be further enhanced through more systematic deployment. Play can help, for example, to bolster the therapeutic alliance and afford the therapist easier access to the inner problems of his patient. Even with minimal intervention or interpretation, the playing child may improve in a way comparable to the relief that certain dreams afford the dreaming adult even before he has understood their meaning.

The play equipment itself has been overemphasized by some therapists and underrated by others. For Lowenfeld, it consists of no more than the culinary implements and raw food material in the kitchen. "It is what the cook does with these implements and food elements that determines the dish." Lowenfeld provided her patients with an entire world in which the child could reconstruct his inner vision of life together with the rules and

regulations that govern it. In a rough sense, the outer world is isomorphic with the internal one. Lowenfeld is not so concerned as other therapists in connecting the two but in making contact with the mind behind the construction and understanding it better. Klein was of the opinion that the play material should be essentially nebulous and malleable and therefore easily convertible to the child's projected needs. Bender insisted that one could do play therapy with children near the equator using sand, stones, and palm trees, and in the arctic regions, snow and ice, since it was important for the material to be meaningful to the lives of the children. Many play therapists maintain a separate box of play equipment for each child patient that remains at his service throughout his treatment. The contents of a box is often a motley collection of things that allows for the expression of family feeling, aggression, regression, rivalry, and restitution.

In the older child, games can substitute for play and can be used ingeniously by the therapist to portray the essentials of both interpersonal and intrapsychic conflicts. Loomis, Gardner, and others have described how the game of checkers, played since the days of the Pharaohs, can be used as a modality in therapeutic work with children, helping to externalize a large number of problems. The game ingredients, described by Redl, can be adapted with advantage to the progress of treatment. Winning or losing, playing fair or cheating, laying traps for your opponent, sacrificing in order to gain, manipulating the ground rules, giving up under pressure, playing

chaotically or compulsively, breaking up the game, and losing interest or becoming tired may all reflect the current intrapsychic state of the child and his interpersonal situation with the therapist. Some have gone so far as to call this “checkers therapy,” but it is really no more than a sometimes useful maneuver when the verbal interchange has come to a standstill.

### **Conditioning Therapy**

The classic study in this field is Watson and Rayner’s conditioning of a fear response to a white rat in a little boy called Albert, and this was followed a little later by Jones’s methods of eliminating fear, using such procedures as disuse, verbal appeal, negative adaptation, repression, distraction, direct conditioning, and social imitation. Only the methods of direct conditioning (or deconditioning) and social imitation proved very successful. Behavior therapy is based on the assumption that the symptom is the illness and not merely the external manifestation of some underlying disturbance. On the basis of learning theory, behavior can be reinforced or inhibited at the discretion of the therapist, and some behaviors may be replaced by others considered less disturbing to the environment. The changes are not only produced rapidly but are observable, and from this point of view behavior therapy is more likely to impress the unsophisticated patient or parent than treatments conducive to an alteration of inner state without external evidence of that state.

## The Basic Ingredients of Child Therapy

### Theory and Child Therapy

Therapists vary considerably in their need of theory or technique. There are some who need a minimum of both and rely on the impact of their personalities (often charismatic in these cases) on the patient. The child improves because he is impressed by the therapist, wishes to please him, and wants to be like him. Other therapists are top-heavy with theory or so dedicated to the exclusive use of particular techniques that much of the flexibility and spontaneity are eliminated from the treatment, with a consequent deadening of the process. An adequate therapist gradually learns to weld theory, technique, and experience into his therapeutic style, making it both personal to himself and generalizable to the theory and practice of other practitioners.

Psychoanalytic theory has the advantage of emerging from psychoanalytic practice and at the same time influencing the nature of that practice. The tripartite structure of the psyche, according to psychoanalysis, helps to illuminate the process of therapy in every stage of its development. The id impulses are constantly striving to make themselves conscious and achieve fulfillment, either completely or derivatively. The ego struggles as actively by means of a complex system of defenses to keep such impulses from consciousness. In analytic treatment, this aspect of the ego's function

comes under analysis. Since the purpose of analytic treatment is to enable repressed instincts to enter awareness in ideational form, the ego automatically sets up defenses against the analysis and eventually the analyst. This resistance to the analyst's work eventually becomes part of the transference resistances. The ego defends itself not only against the instincts but also against the effects associated with the instincts, and it develops a wide variety of measures to master the concomitant feelings. These ego defenses vary with the stage of development, and the child analyst may therefore find himself dealing predominantly with different defense mechanisms, not only in different patients at different developmental stages but also in the same patient at different phases of the treatment. In later childhood some of the resistances become incorporated into the character and are therefore extremely laborious to analyze because of the apparent absence of intrasystemic conflict. In the treatment process of child analysis, the technique often begins with the analysis of the patient's defense against affects and then proceeds to the investigation of the transference resistances. In the early days of psychoanalysis the following reasons were given as to why the child was not analyzable in the usual sense of analysis: A child generally did not come voluntarily to treatment; he was generally not able to relax on a couch; he was not able to free associate; he was unable to develop a transference neurosis; he was unable to work through certain resistances; he was unable to undertake dream work; and his ego and superego were too

immature to deal with anything but a minimum of id material. In the last few decades the situation has changed remarkably, mainly because of the influence of Melanie Klein, who had insisted from the beginning that the analysis of the child was in every way comparable to the analysis of the adult. Anna Freud has since come to an almost similar conclusion, although by a different path. Klein felt that a free flow of play was equivalent to the free flow of a patient's thoughts and that the content of play can therefore be treated as associations. Anna Freud was unable to accept this equation, but, for her part, thought that the analysis of affects as they undergo transformation in treatment may offer opportunities similar to free associations and have, moreover, the advantage of not requiring the child's voluntary cooperation. Freud is currently in agreement with Klein that transference neurosis can develop in the child and is susceptible of analysis. As in the case of adult psychoanalysis, transference has gradually come to occupy a major role in child analysis.

The Rankian approach is somewhat different. Transference, like resistance, is accepted as a stage in the growth process of the self becoming autonomous. The analyst tries to accept what is happening without letting his own feelings interfere with the young patient's struggle to find himself. It is up to the child to do what he can for himself with the steady support of the analyst, the latter tolerating all the vicissitude of the transference. The Rankian emphasis on time may play an integral part in the treatment, and its

most crucial development may lie in dealing with the series of endings and separations that analysis, like life, imposes on the situation. The termination, willed and accepted by the patient, is an active beginning as well as ending. In all this the therapeutic process becomes strangely coterminous with the life process.

In child analysis, therefore, the unconscious conflicts underpinning a neurosis are interpreted systematically; the transference manifestations may develop and may mature to a full transference neurosis; the Oedipus complex is reached, worked through, and resolved in keeping with the psychosexual level of the child, and treatment is carried out three to five times a week for as long as four to five years.

By comparison, analytic psychotherapy with the child is directed at the alleviation of a specific neurotic symptom or the reduction of some related anxiety by means of interpreting the specific underlying conflict. The therapist attempts to stabilize the reasonably intact personality of his patient and to prevent any aggravation of pathology. He attempts to function as a real rather than as a transference object, to deal with current reality, to respond actively with verifications, suggestions, and reassurance, to encourage the expression of thoughts and feelings, to leave useful defenses alone, and to deal with dynamic rather than genetic issues. In so doing, according to Brody, he cannot but develop a "parental aura." He usually sees the patient not more

than once or twice a week over a period of one to three years. Brody felt that the psychoanalytic framework is the only practical one for effective child psychotherapy because, as she said, "if psychotherapy is to be rational, one theory of personality development and of symptom formation must obtain for all methods." McClure outlined the basic principles of play therapy somewhat differently. In her scheme, the therapist must attempt to make contact with the child's unconscious, split the ambivalence, participate in the guilt released, probe no deeper into the unconscious than is necessary for therapy, and foster a reconstruction of the personality on its own lines, true to its own basic reaction type. She grouped patients according to their reaction types (hysterical, obsessional, and labile) and modified her therapeutic activity accordingly. With the hysteric the therapist attempts to act as a stabilizing force and then to find, in the historical emotional environment of the child, the obstruction that first disorientated the child's reactions. With the obsessional the therapist attempts to harness the creativity of the child, especially in terms of his fantasies of punishment, and with this will come the first contact with the child's feelings. With the labile reaction type much of the treatment can be carried out at a positive, extroverted reality level, attempting to give the child some insight into the restraint of his primitive impulses. McClure pointed out that verbal interpretation can be helpful but should not be systematic or intellectual. In general, she stated that the therapist should adopt a warmer approach toward obsessional than toward

other types of children.

### **Within the Therapeutic Environment**

Milner likened the therapeutic environment to a framed picture, the frame standing for the boundary between the comparative unreality and illusion within the frame and the everyday reality outside it. The frames (or walls) are there to specify that the situation is unusual and that what takes place can occur nowhere else in the outside world. The frame may be complete or incomplete, or the system may be closed or open. In the case of younger children many therapists prefer to work with an open system that allows regular contact with the parents so that information they give may be used in the service of therapy. However, such openness may lead to problems of confidentiality even in very young children, who may rapidly assume a conspiracy of adults attempting conjointly to domesticate them. The parents, in fact, represent a technical problem for all ages of children, and the general rule is to involve them less in the system in direct relation to the age of the child.

The therapist creates the therapeutic environment in which he is best able to work, but to some extent his therapeutic posture is determined by his theoretical leanings. If he is a classical child analyst, for example, he takes his stand at a point "equidistant from the id, the ego, and the superego." If he is a

Rankian, he must “maintain his own realness,” provide a “steady background,” and help the patient gradually to be himself, gain a sounder evaluation of his own differences, and become free to make creative and responsible use of these differences in the continuing realities of his life. Allen had enough confidence in this approach to state, somewhat categorically, that “we have gone far beyond the idea of therapy as the application of techniques and the giving of insight.” If he is a Rogerian, the therapist is basically nondirective, but within the relationship he is warm and friendly, establishes a good rapport as soon as possible, accepts the child exactly as he is, establishes a feeling of permissiveness so that the child feels free to express his feelings completely, reflects these feelings back to the child in such a way that he gains insight into his behavior, maintains a deep respect for the child’s ability to solve his own problems if given an opportunity to do so, encourages the responsibility to make choices and to institute change, and establishes only those limitations necessary to anchor the therapy to the world of reality and to make the child aware of his share in the relationship. The child always leads the way, and the therapist follows unhurriedly. These are the basic principles outlined by Axline by means of which she structured the therapeutic alliance.

All therapists are aware or should be aware that during the other twenty-three hours of the day the child is exposed to a variety of pro- and antitherapeutic forces operating in his general environment. Unless the

therapist makes himself aware of these factors he may find to his surprise that his patients make sudden and inexplicable therapeutic changes for the better or worse that leave him surprised and perplexed. He may understand fully what is going on in therapy but not what is going on outside therapy. The facilitating environment may have special significance for certain needy and dependent children without too much autonomous capacity of their own.

Erikson structured the world of the playing child into three areas: a sphere directly related to the small manipulatable toys with which he plays; a sphere relating to his body; and a sphere relating to the larger world. The therapeutic environment can be differentiated in the same way: a microsphere where the child can project his internal feelings and conflicts; the autosphere to which he retreats or regresses in a need of comfort and satisfaction; a macrosphere which contains the rest of the environment; and the transference sphere containing and surrounding the therapist. The child's movements within this system can be plotted and interpreted in relation to the significant figure of the therapist.

Winnicott's full conception of the therapeutic environment was in dynamic terms. Every part of it—the resisting walls, the openings into the outer world, the little things that could be broken and put together again—were all understood in dynamic terms, as if the environment was structured rather like the mental apparatus.

The therapeutic environment congenial to relationship therapy has been fully described by Moustakas. It has been compared to the atmosphere of a Japanese tea ceremony: harmonious, reverential, pure, and tranquil, exuding a constant sense of peace. All this sounds remote from the often scarifying, disturbing child analytic situation in which murderous and incestuous wishes and fears may pervade the environment. As Klein remarked, the psychoanalytic treatment of children is not a gentle matter, since the impulses involved are far from gentle. It would not be feasible to conduct a child analysis in the atmosphere of a Japanese tea ceremony.

The therapeutic relationship that develops within the therapeutic environment begins first with the breakdown of strangeness, the establishment of confidence and trust in the therapist, the resolution of the initial suspicions and misgivings and fears, and finally the growth of a therapeutic alliance in which the observing and healthy portion of the patient's ego joins forces with the therapist in the battle against the patient's neurosis. The relationship undergoes many changes during the course of therapy; sometimes it is used for symbiotic ends, for regressive needs, for the working out of transference, for support, for understanding reality, for transitional purposes and for learning how to become therapeutic with regard to oneself. The communications that punctuate this relationship are frequently nonverbal, empathic understandings that need no overt expression, sometimes comments, sometimes questions, sometimes direct

confrontations, and every now and then, when the timing is appropriate, an interpretation given with tact and clarity in brief and concrete terms.

As the child moves from one sphere to another in relation to the therapist, from one mode of expression to another in terms of his fantasies, dreams, play, games, and dramatic performances, he also passes through cycles of affect that follow one another in logical sequence: Aggressiveness, giving place to guilt, and then to fear of retaliation, and then to the desire to make reparation, eventuates in loving feelings and a movement toward the therapist. Erotic feelings may be followed by fears of seduction and penetration, giving place to anger and attack and distancing from the therapist.

Newcomers to the field of child therapy are often puzzled by the vague and nebulous content of the sessions and the capacity for the child to be productive in the therapeutic situation without need to communicate. Even after long experience the child therapist must be prepared to deal with less certitude than the adult therapist. A gifted commentator, outside the field, had this to say about the contact with children: "Children need not talk, even when they can. Much goes in but little comes out. We may ask but win few direct answers. We can at best only interpret. ... I believe those who can win nearest to childhood and be wholly at peace, at liberty, and at ease in its company would be the first to acknowledge that they can never get nearer

than very near, never actually there.”

## **Preliminary Considerations in Child Therapy**

### **Assessment of Therapeutic Potential**

An important part of the diagnostic process is the assessment of therapeutic potential, which is a global consideration depending in part on factors in the child, in his family, in the community around him, and in the clinician or clinical team that is preparing to treat him.

The important factors in the child have to do with the extent of the disturbance, its duration, the amount of secondary gain deriving from the symptoms, and the proportion of reactive to internal elements in the disorder. A second area has to do with the personal characteristics of the patient, such as his stage of development, his capacity for relating to others, his ability to conceptualize and communicate, his tolerance of anxiety and frustration, his repertoire of defensive and coping mechanisms, his potential for transference, his “psychological mindedness,” and his proneness to regression. The third area is related to the personality as a whole in both its healthy and unhealthy parts, considered separately with regard to drives, conscience, and ego, especially in its conflict-free functions. The final area is concerned with the degree of physical and central nervous system

impairment.

In more detail, the evaluation attempts to assess the cooperation and motivation of the parents, their familiarity with psychological treatment, their experience of treatment with other children in the family, their sophistication with respect to inner and unconscious factors or causality, and their general belief in the malleability of the human psyche. In the developmental context, significant factors include the quality of the primary mother-infant relationship, the presence or absence of pregenital fixations, the intensity of the symbiotic tie to the mother, the presence or absence of Oedipal configurations, and the amount of trauma, such as separation, hospitalization, illness, death, or divorce, in the early part of the life cycle.

Psychological elements within the child include his level of intelligence, the availability of his affects, his introspectiveness, his recognition of problems and willingness to consider them, and his motivation to come “in order to get on better.”

The characteristics of the family as a unit, whether stable, cohesive, divisive, close, or distant, and its relationship, in turn, to the community, whether isolated or involved, may also exert a determining influence on the child’s level of therapeutic responsiveness. To the extent that he also shares in a general family pathology that is in a relative state of equilibrium, this can

also impede the progress of change. The child's role in the psychic economy of the parental relationship is sometimes so crucial that a shift in his balance is likely to prove disruptive to the marital tie. The extended family of near and distant relatives may also play a part in supplementing, implementing, or undermining the therapeutic management, particularly when they become part of the practical arrangements and are required to transport, babysit, or pay the fees. The arrangements in general have to be carefully considered in the overall assessment and should not add a burdensome load of their own to the treatment undertaking.

The factors in the community that may affect therapy, either positively or negatively, include the school and its investment in the child, the child's pediatrician and his attitude toward psychological treatment, and religious and social organizations in close touch with the family.

The result of the assessment should generally throw conclusive light on the treatability of the child, but this is sometimes still in doubt after all the factors have been carefully considered. It is then good practice to undertake a trial period of therapy before any child is labeled "untreatable." There are many children who are unreachable and untreatable when the classical techniques are rigidly applied but who respond very well following a period of preparation or modification of method. These and other related matters have been fully considered in a recent report.

## **Assessment of the Degree and Level of Disturbance**

Although it is customary for the growth and relationship school of child therapy to eschew the process of diagnosis and to endeavor to meet the child where he is, the more usual practice for those working with the medical model is to make a careful diagnosis and construct a diagnostic profile or working model of the child's therapeutic strengths and weaknesses prior to any consideration of treatment. The diagnostic classification that has most to recommend it for ordinary clinical purposes has the additional advantage of some research evaluation. Its most striking feature is the inclusion of a diagnostic category of health (rarely considered when a child is referred to a clinic) as well as the further useful category of developmental deviation.

A special psychoanalytically orientated profile has also been devised by Anna Freud and her colleagues, which is based on both external factors, such as the referral symptoms, the family background and history, other possibly significant environmental influences, and internal factors dealing with the structure of his personality, the dynamic interplay within the structure, the economic factors relating to the relative strength of id and ego forces, the psychogenetic assumptions, and the adaptation of the child to the realities of his circumstances. In the overall consideration the total personality of the child is scrutinized in terms of his frustration tolerance, his sublimation potential, his handling of anxiety, and the proportion of aggressive to

regressive tendencies.

## **Differential Treatment Planning**

This important interlude is fully considered in a Group for the Advancement of Psychiatry report. There is sometimes an awkward gap between diagnosis and treatment, which may be extended indefinitely by a lengthy waiting list procedure. The logical sequence of events that take place in the interim period following evaluation is often unclear not only to the clinician himself but also to the family. Most clinics today have progressed beyond the point where a patient is rejected as being unsuitable for treatment. Clinics are increasingly able to provide a range of treatments to match a range of diagnoses, so that individual, group, family, psychoeducational, drug, and behavior therapies are prescribed after very careful consideration of the diagnostic circumstances. For purposes of treatment planning, diagnostic classification in the narrow sense of the child's liabilities is insufficient and at times even misleading and needs to be complemented by a differential assessment of his assets. The planning may result in a number of treatment recommendations in which one or more may be combined, and although the clinician may favor a particular approach, he may well alter his recommendation after full discussion with the family. The consumer's point of view is therefore represented in the final plan. Communicating the findings and recommendations of the clinician to the

child and his family is a small art in itself, and strong resistances may arise when suggestions are made in an atmosphere of reproach instigating guilt and shame. Resistance may also arise from a lack of clarity or a failure to empathize with special anxieties and concerns at the receiving end.

### **The Course of Treatment**

An overall view of treatment generally tends to categorize it into a beginning, middle, and terminal phase, which Freud once compared to a game of chess in which the opening gambit and end game could be taught and learned to some extent. The long phase between the two was so complex in its development that the student had to learn to play it by ear with the help of certain general principles and a variety of technical procedures.

Anthony made an attempt to trace the evolution of the therapeutic process in individual psychotherapy and child analysis. In his paradigm he envisaged four stages in treatment:

1. There was a varying period of initial contact during which familiarization to the therapeutic environment and to an unknown person occurs. The duration of this stage bears a close relationship to the level of anxiety that the patient brings in with him and to his habitual sensitivity to strangers and strange situations. It is essentially an encounter between real people, with transference factors playing a minimal part.

2. The next stage, termed Phase I, functions essentially as an open system modeled on the early parent-child union with its anaclitic-diatrophic form of relatedness. Communication is dominated by primitive ego functioning on the part of both therapist and patient, with heavy reliance on empathy, intuition, imitation, and identification. The patient's thinking is largely of the primary-process variety and is apt to be colored by ideas of magic and omnipotence. The focal conflict has to do with dependency and the ambivalent feelings engendered by it. In keeping with this issue, the drives are predominantly pregenital in origin, with attacking and sadistic elements especially prominent. The symbiotic transference tends to be floating and sporadic, and the countertransference is parental in orientation, involving areas of care, contact, and control. The major therapeutic influences at work involve suggestion, persuasion, and catharsis, and consequently the therapist's personality plays a crucial role in directing the course of treatment. The therapeutic task for this first phase comprises the resolution of the ambivalent dependency, the crystallization of identifications into a more genuine object relationship and a corresponding individuation of the patient as a whole.
3. As a result of these developments, the course of treatment undergoes an often dramatic transformation, which is characteristic of Phase II. During this state the therapeutic system can be described as closed, and the working therapeutic model would include representations of both mother and father within a triangular frame of reference. Communication is typically verbal and explicit, and the

thinking operations of both patient and therapist involve logical secondary processes, with the observing ego of the patient demonstrating a capacity for doing a certain amount of analytic work itself in the form of self-analysis and working through, indicating that the therapist, as therapist, has been to some extent internalized. Because libidinal drives are more to the forefront, there seems to be a general softening of the treatment milieu. It is during the course of this stage that transference neurosis develops and is resolved with the methodical use of interpretation and defense analysis. The countertransference experiences show erotic and genital components, depending on the sex of the patient and the positive or negative direction of the therapist's Oedipal complex.

Anthony was of the impression that for the majority of cases seen in a children's psychiatric clinic, the Phase I period of therapy only is sufficient, since the resolution of the ambivalent dependence could lead to lasting changes within the personality through the medium of identification. In certain cases, however, where the neurosis is classical, circumscribed, internalized, and structuralized, a shift to Phase II becomes necessary. When this fails to occur, the fault may be attributable to unforeseen diagnostic complications in the patient, to the excessive use of gratification in the treatment environment, or to certain subtle countertransference resistances in the therapist himself.

4. With the passing of the transference, a termination stage can

usually be demarcated during which the therapist once again emerges predominantly as a real person who is more knowable than the previously nebulous transference figure. This person-to-person encounter is associated with a general mellowing of the therapist's affective response toward the patient, and the major therapeutic work to be conducted in this phase focuses on the separation anxiety stimulated by the prospect of termination.

In the relationship field, Moustakas also described stages in treatment under the aegis of a therapist who believes deeply in his patient as a person and in his potentialities for growth. At the beginning, the child is required to become aware of his real feelings, fear, anger, immaturity, and destructiveness. As the relationship with the therapist is clarified and strengthened, the child's deeper feelings of hostility also become gradually sharpened, and anger is expressed more directly and more relevantly to the person or situation concerned. At the next stage, he is no longer so completely negative, and ambivalent feelings, both negative and positive, predominate. In the final stage, positive feelings emerge, and the child begins to see himself and relations with people more as they really are. In the anxious child, as opposed to the angry child, anxiety is at first all-pervasive and general and then begins to crystallize around some particular person. At this point, he feels very inadequate, and this persists until the next phase when the doubts about himself are gradually replaced by confidence and courage, though for a while the child oscillates between these two sets of feelings. Finally, he

becomes clear about positive and negative fears toward particular people and can relate them to actual situations, and when this happens they slowly diminish in intensity.

In children who have not undergone a primary mothering experience, to use Winnicott's term, and in children heavily traumatized in the first period of life and who have developed what used to be called primary behavior disorders, there is often a singular lack of motivation and anxiety on which to base the treatment. A long period of preparation for treatment may finally result in the emergence of a treatable child, but the task of preparation is not easy, and the chink in the armor may be hard to find. Work with the parents may make all the difference between success and failure in treatment.

The classical treatments have not only been modified for certain previously untreatable disorders, but they have also been shortened to fit the needs of acute or critical circumstances. Release or abreactive therapy for the traumatic neuroses has already been mentioned. Green and Rothenberg suggested certain guidelines in the first aid treatment for children. In order to prevent emotional damage to the child, they advised that the parents be informed of the possible risk to the child involved in the situation and educated in the role of secondary prevention by receiving an understanding of the child's language of behavior in nontechnical terms. The parents are given some concrete and practical advice, such as the need to maintain self-

control in the child's presence, the importance of listening to the child without teasing, ridiculing, or beating him for his symptoms, of allowing him to recount his complaints as often as he wishes, of not telling him to go away and forget his problems, of investigating the situation as much as possible before taking action and not pushing the child into any frightening or disturbing situation to which he feels unequal. Listening, encouraging, reassuring, abreacting, and interpreting are the foundations of these short-term therapies. With younger children, treatment can often be abbreviated by working with the parents to affect those environmental forces playing on the child. The reason why brief interventions are so effective in the emotional predicament of crisis is that at these times the defenses are labile and the cathexes fluid. Caplan (quoted by Klein and Lindemann) likened the critical intervention to the giving of a gentle push to a man standing on one leg, thereby hoping to restore him to his pre-crisis balance; the results are also gained with much less effort than might generally be required. However, although the push may be gentle and brief, the inner reverberations set up by it may continue long beyond the actual encounter. Stierlin argued that certain developmental crises may be propitious occasions in which you may alter life situations so that the decision as to when to treat may be a crucial therapeutic decision. The therapist's responsiveness and sensitivity carry even greater importance in brief than in long-term therapy. Malan pointed to some of the advantages of the time limited situation. The brevity of contact makes it

easier to tolerate the tensions and negative feelings engendered by the relationship. The therapist tries to deal with termination at the onset of therapy, activating the capacity to mourn. The end of treatment, therefore, becomes the main focus of the therapeutic process.

Behavior therapies of various kinds are becoming increasingly used in child guidance clinics. Phobias have been desensitized; disturbing symptoms have been eradicated by punishment and nonsymptomatic behavior reinforced by rewards; social adjustment has been improved by means of treatment based on social learning theory. The results obtained are often so striking that it is not surprising that more and more clinics are climbing on to this particular bandwagon. More recent evaluations, however, especially long-term ones, are less enthusiastic, and there have been several suggestions in recent years that insight and behavior therapy are not mutually exclusive or incompatible and might advantageously be used in conjunction.

### **The Role of the Therapist**

Child therapy is an arduous business, and few child therapists remain active practitioners beyond the fourth decade; thereafter, they either tend to switch to adult patients or become supervisors. The wear and tear of person and property can be considerable and discouraging and, to paraphrase Winnicott, there are at least twenty-one good reasons why the average good

enough therapist sometimes hates his child patient. He may hate him because he is unwilling to come, reluctant to stay, and eager to go; he may hate him because he is obstinately silent, garrulously irrelevant or monotonously confined to clichés, such as “I don’t know.” He may hate him for being physically aggressive, destructive, or dirty and messy; for inquisitively investigating all his private drawers and papers; for demanding food and rejecting interpretations; for making the therapist doubt his theory, his technique, his ability to understand even himself. There is no other situation that engenders so much countertransference for the therapist except perhaps the treatment of psychosis.

Apart from feelings generated by the patient, the therapist may also react to the child’s parents, by identifying either with them against the child or with the child against the parents. In both instances the responses ricochet on the therapist.

The facilitating factors that the child therapist brings with him to the treatment situation are his empathy, deriving from his own mother-child relationship, his capacity to tolerate immaturities, his ability to regress therapeutically along with his patient, a general familiarity and at homeness in childhood, and a childlike quality that is often recognized immediately by the child patient and responded to with a sense of kinship. A touch of anality makes the general messiness of child therapy not so distasteful to the child

therapist.

The psychological distance between the child therapist and his child patient is therefore much less than that between the average adult and child, and further bridging measures include a learned capacity to talk to the child without condescension. Anthony commented on the usefulness of Piaget's technique of clinical interrogation in communicating therapeutically with children, and Gardner introduced a special technique of storytelling which is tape-recorded during the treatment session. The therapist also tells a story following a few principles of story analysis, similar to dream analysis. In the story analysis, the symbolic significance of each figure is clarified, and the moral of the story becomes a dynamic interpretation.

The therapist therefore plays a large number of roles in child therapy, and he wears so many hats that he is likely at times to become confused or feel confused. He can be a real figure, a transitional figure, a transference figure, a parent surrogate, a trustworthy friend, an untiring playmate, a model of good consistent adult behavior, a seductive agent in the expression of bad, aggressive, and erotic thoughts, a prohibitor and limit setter, a frightening "head shrinker," and above all, someone who has an uncanny sense of what it feels like to be small and helpless and who knows, in Erikson's terms, "the humiliation of being a child."

## Evaluation of Child Therapy

Psychotherapy outcome studies are logically necessary within the framework of scientific treatment. It makes not too much sense to stress the exactitudes of diagnosis and the details of treatment planning if there is a lack of confidence in the treatment that follows and a lack of knowledge of its efficacy. Outcome studies are so difficult to carry out in a way that would please both the practitioners and the research pundits that each year finds a decrease in the number of investigations undertaken. The old crude methods of evaluation have given place to the setting up of laboratory analogues, computer simulation, and psycho-physiological measures, but nearly all the studies to date suffer from the same deficiencies—narrow and superficial scope with little clinical depth, follow ups undertaken too soon, therapy variables contaminated by interpersonal affects, and no real control of observer bias.

Anthony reviewed the outcome studies in child therapy and came up with the usual admixture of findings, similar to the results in adult therapy. The variables are so many and so complex that it is almost impossible to find comparison and control groups.

There have been more than eighty studies of the effects of various psychotherapeutic techniques in which some form of control procedure or comparison has been made. Of these, about seventeen have had to do with

child psychotherapy. Heinicke and Goldman carried out a review of these studies, in all of which some type of eclectic psychotherapy was used and at least three criteria of outcome status were employed during the follow-up study. A pooling of these studies revealed that in approximately 80 percent of the cases, psychotherapy was found to be either completely or partially successful at follow up.

Although such results were extremely favorable, the question is whether these children would have changed as much without therapy. Favorable environmental influences or normal maturational processes could have led to the disappearance of the difficulties. Therefore it was clearly not sufficient to pronounce in favor of psychotherapy without comparing the degree and quality of change in children equivalent in all respects except that they do not receive psychotherapy.

A number of factors may have been responsible for the lack of significant differences between the two groups. The children were examined five to six years after treatment, and some of them had only a very brief course of therapy. The longer the follow up, the more likely the specific effects of treatment are to be overshadowed by life experiences, so that the differences between treated and untreated are likely to decrease with the passage of time. Again, the children followed up and tested were only a small proportion of the initial sample and therefore may not have been

representative. However, an average of 18 percent of parents gave improvement in the child as one of the reasons for defection, and therefore the defectors may have had a larger proportion of remissions before they were due for treatment. It is thus doubtful whether defectors can be regarded as a suitable control group.

In summing up, it is clear that psychotherapy research has been carried out on greatly varied samples, and the techniques of treatment and assessments employed have been so diverse that some of the studies have very little in common. The evidence would suggest that all the various methods of psychotherapy with children are effective to a degree and that different techniques lead to changes of a different kind.

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