



1949

## A comparative analysis of four types of psychotherapy used with children

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A  
COMPARATIVE ANALYSIS  
OF  
FOUR TYPES OF PSYCHOTHERAPY  
USED WITH CHILDREN

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212 1 12

by  
Margaret P. Moore

Stockton, California

June 1949

A Thesis  
Submitted to the Department of Psychology  
College of the Pacific

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In partial fulfillment  
of the  
Requirements for the  
Degree of Master of Arts

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APPROVED *Alfred W. Mitchell* Chairman of the Thesis Committee

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## CHAPTER I

### REVIEW OF THE LITERATURE, THE PROBLEM AND DEFINITIONS OF TERMS USED

Psychotherapeutic work with children started in 1905, when Dr. Sigmund Freud undertook the first child analysis. The third decade of the twentieth century saw the beginnings of the work of Melanie Klein and Anna Freud in Europe, and the growing strength of the child guidance movement in this country.

#### Review of the Literature

Melanie Klein and Anna Freud began to write books about their work with children, and therapists in this country began to develop methods that were successful in treating mild forms of maladjustment. Such names as Frederick Allen, Jessie Taft, Carl Rogers, John Levy, and David Levy became prominent due to their work, their publications, and their lectures before learned societies.

The American Orthopsychiatric Association could claim in its membership all those who were doing original and outstanding work in the field of psychotherapy with children. As a result many of the articles written about this subject appeared in the official organ of the association. In addition, as interest grew and as diverse opinions developed,

the association attempted a gathering of child therapists, and at section groups of their annual meeting, they urged discussion of important points. One such discussion was held in 1938 and reported in the October issue of the American Journal of Orthopsychiatry. Another was held two years later and reported in the October issue of their journal for the year 1940.<sup>1</sup> However, there was no attempt at analysis of points of agreement or disagreement. In both cases there were summaries by the chairmen of the groups, but they were an opportunity for the leaders to add their opinions rather than a true synopsis of the material offered by the participants.

### The Problem

In reading the books and articles written by the outstanding therapists, it appeared that four types of dynamic psychotherapy with children could be distinguished with respect to their basic concepts and definitions of the methods of psychotherapy. These types are known as Child Analysis, Relationship Therapy, Non-Directive Play Therapy, and Directive and/or Release Therapy. It was possible to extract from the material statements concerning their concepts of life

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<sup>1</sup>Goodwin Watson, Chairman, et al., "Areas of Agreement in Psychotherapy", The American Journal of Orthopsychiatry, 10:678-710, October 1940.

and psychic structure, the aims of therapy, definitions of the therapeutic situation and several therapeutic techniques, as well as opinions of criteria for a good prognosis and descriptions of the role of the therapist, child and parent.

It seemed advisable to make an analytic comparison of such statements and descriptions in order to discover points of agreement and disagreement or differentiation between the four schools of thought. It was felt that such a comparison would aid the student of psychotherapy with children in formulating his method of approach to such work and give him a background for further study in this field.

#### Definitions of Terms

One term that has led to much heated discussion and misunderstanding is the title play therapy. The two words were first used to describe the new technique of Melanie Klein, who developed a play situation to attain rapport with child patients to replace the classical method of free association. By 1938 when there was a section on play therapy at the annual meeting of the American Orthopsychiatric Association there was a split in the ranks of the therapists. There were those who believed that play was the therapeutic tool of most importance and those who maintained that it was merely a method of putting the child at ease so that a close relationship could be established between the child and therapist.

At that meeting Margaret Gerard, Associate Professor of Psychiatry at the University of Chicago made the statement that "play is the tool by which we gain a relationship with a child."<sup>2</sup> However, as she continued, she stressed the important cathartic value of play. Frederick Allen paraphrased her words when he said the "play provides the child with a natural medium for establishing a relationship with one whose interest in a contact with the child is established around the fact that the child needs help."<sup>3</sup> He attributed even more to play when he added: "Play is the best entree into a child's fantasy life and the child may be directly led into those forms of play that will best serve that purpose."<sup>4</sup>

Miss Helen Ross, a consultant at the Institute for Juvenile Research, was a member of the same meeting and she indicated the therapeutic value of play when she stated that the "psychoanalysts discovered that play is the language of the child and an important vehicle of his abreaction.... Through play he can demonstrate his fears and way of solving them."<sup>5</sup>

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<sup>2</sup>Frederick Allen, Chairman, et al., "Section on Play Therapy", The American Journal of Orthopsychiatry, 8:520, October 1938.

<sup>3</sup>Ibid., p. 512.

<sup>4</sup>Loc. cit.

<sup>5</sup>Ibid., p. 505.

A child psychiatrist at the School of Medicine and Institute of Human Relations at Yale University, Dr. Homberger, put it nicely when he said that the definition of play therapy revolved around the concept of talking it out versus playing it out.

Playing it out is the most natural autotherapeutic measure childhood afford. The child attempts to restore his psychic integrity by mastering in play a sphere of reality in which his acts are physiologically safe, socially permissible, physically workable, and psychologically satisfying.<sup>6</sup>

At the 1939 meeting of the association, Dr. David M. Levy stated that the child uses his imaginative play as an important method of getting rid of tension arising out of anxiety.<sup>7</sup> Even more recently Axline wrote in her book:

Since play is his natural medium for self-expression, the child is given the opportunity to play out his accumulated feelings of tension, frustration, insecurity, aggression, fear, bewilderment, confusion. By playing out these feelings, he brings them to the surface, gets them out in the open, faces them, learns to control them, or abandon them. When he has achieved emotional relaxation, he begins to realize the power within himself to be an individual in his own right, to think for himself, to make his own decisions, to become psychologically more mature, and by so doing to realize selfhood.<sup>8</sup>

Thus it would seem that in an analysis of four types of dynamic psychotherapy used with children, one can use the following as a workable definition of play:

Play is the natural language of the child by which he

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<sup>6</sup>Ibid., p. 597.

<sup>7</sup>"Trends in Therapy" - a symposium, The American Journal of Orthopsychiatry, 9:715, October, 1939.

<sup>8</sup>Virginia M. Axline, Play Therapy (New York: Houghton Mifflin Company, 1947) p. 16.



imparts to others his fantasy life, his problems, his fears and his joys, which he is unable to put into words because of fear, anxiety, or unfamiliarity with the spoken or written word. It is the natural way for the child to gain relief from tension arising out of fear, anxiety or extreme joy. Through play the child can establish psychic equilibrium by acting out or reliving experiences that upset this balance; for the play situation is one in which his acts are physiologically safe, socially permissible, physically workable, and psychologically satisfying.

This definition indicates that psychic adjustment is constantly being made by the child. Of late years all schools of psychology have emphasized the ever-changing quality of psychic phenomena and the human quality of constantly adjusting to each situation in a manner that is most economical of psychic energy. With this as a basic concept it must follow that a situation that arouses great fear or anxiety will be met in a manner that will conserve the greatest amount of psychic energy. This leads to a concept of maladjustment that holds that what appears to be abnormal to society is in reality consistent with the personality and emotional structure of the individual.

These four groups of psychotherapists accept this concept of maladjustment and take a dynamic approach to treatment. They maintain that a child will approach a new situa-

tion, namely the therapeutic situation, in a manner that is consistent with his past behavior since all his activity is determined by his psychic structure. If the therapist can understand this structure, especially the emotional components, and through therapy give the child an opportunity for a greater or lesser understanding of himself and his emotions, then he may be able to effect a cure or improvement.

Therefore when the terms dynamic and dynamics are used in this thesis they will refer to the concepts of constant change in psychic phenomena, that of the economic use of psychic energy, and the need for the establishment of psychic balance.

The above definitions of play therapy and dynamics of adjustment are good points of reference for beginning a concise, analytic comparison of the concepts and techniques that a basic to the four types of dynamic psychotherapy used with children in the United States. These types are labelled Child Analysis, Relationship Therapy, Non-Directive Play Therapy, and Directive and/or Release Therapy. Each group incorporates the concept of human growth and integration in a permissive environment with the recognition of the economy of a neurotic adjustment to an overwhelming situation.

There are many points upon which they differ, due to an emphasis upon a particular definition of the therapeutic situation and the roles of the child, therapist and parent

during the period of treatment. In addition there are distinctions in the selection of techniques and the purposes of the techniques that are used. However, a critical analysis and comparison of the tenets, postulates and methods of each of the four groups are necessary in order to clarify the meaning, viewpoint, and methods of psychotherapy with children for the novice, and to give a point of reference to one who would compare his work with that of his colleagues.

## CHAPTER II

### CHILD ANALYSIS

The psychotherapeutic technique which was to be known as Child Analysis began when Sigmund Freud analyzed a five-year-old boy in 1905. It was reported as Analysis of a Phobia in a Five-year-old Boy and was used as source material for the first child analysts. Among these were H. Hug-Hellmuth who released a book entitled Zur Technik der Kinderanalyse in 1921; Anna Freud, whose book An Introduction to the Technic of Child Analysis was published in English in 1927; and Melanie Klein, a true pioneer who embarked upon the project of developing a special methodology for approaching the problems of infantile neuroses. Her book, The Psycho-analysis of Children was published in Great Britain in 1932.

Since that time Edward Glover, M. N. Searl, Joan Riviere, and Susan Isaacs have been occupied with treating neurotic and psychotic children in Great Britain and with clarifying their concepts of child analysis. Heinz Hartmann, Ernest Kris, Berta Bornstein, Human Lippman, and Margaret Fries have been working on the same problems in the United States. Drawing upon the work of Melanie Klein, and Anna Freud, and articles written by Hartmann, Kris, Glover, Bornstein, Lippman, and Fries, there will be an attempt to

define their concepts concerning infantile neuroses and the techniques they employ in treating them.

### Basic Concepts

All child analysts subscribe to the concept of a tripartite theory of the personality, namely the dynamic forces that are known popularly as the id, the ego and the super-ego. This structure was devised by Freud and used to explain the basic causes of neuroses and psychoses. He developed the theory of the psycho-sexual development of the child to explain the genesis of theses three forces. The child is born with an entity of psychic energy known as the libido. "The child's libido organization is in a fluid state, the libido moving on continuously toward new positions."<sup>1</sup> The urges that propell the libido toward gratification of the basic needs are considered as the id. "The id-impulses naturally tend upwards and are perpetually striving to make their way into consciousness and so achieve gratification."<sup>2</sup>

The ego develops in the child as an awareness of the requirements of reality. Anna Freud describes the gradual subjection of the ego to the superego and the role of the ego as referee and arbiter between the two opposing forces

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<sup>1</sup>Anna Freud, "Indications for Child Analysis", The Psychoanalytic Study of the Child, 1:137, 1945.

<sup>2</sup>Anna Freud, The Ego and the Mechanisms of Defense (New York: International Universities Press, Inc. 1946) P. 30.

of the id and superego in these words:

The child's growing awareness of the outside world, the beginnings of his ability to retain and connect memory traces, to foresee events, to draw conclusions from them, etc. are used at first exclusively for the purpose of instinct gratification. This undisputed reign of the instincts does not outlast infancy. As a result of his strong emotional ties to the parents, the child soon begins to consider their wishes, which are frequently in opposition to his own. To the degree in which he is able to identify with his parents, his ego develops hostile attitudes towards his instinctual demands and attempts to oppose and manage them.<sup>3</sup>

In conjunction with the crystallization of these psychic forces, Abraham divided the growth period into separate but overlapping stages and classified them in order as:

1. Early oral or sucking stage
2. Late oral-sadistic or cannibalistic stage
3. Early anal-sadistic stage
4. Late anal-sadistic stage
5. Early genital or phallic stage<sup>4</sup>
6. Latency period
7. Puberty
8. Maturity

Thus in analyzing a child, the analyst tries to determine with which psychic force he is working and at which stage the developing psyche has been fixated due to a traumatic experience.

Psycho-analysis has adopted a preference to charac-

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<sup>3</sup>Freud, "Indications for Child Analysis", p. 142.

<sup>4</sup>Otto Fenichel, The Psychoanalytic Theory of Neuroses (New York: Norton & Company, Inc., 1945) p. 101.

terize psychic phenomena according to their position in the process of development. In the psycho-analytic study of personality, character traits are not grouped according to their similarity in a descriptive sense, but rather according to their common genetic roots. Examples in kind are the "oral" and "anal" characters.<sup>5</sup>

### Aims of Child Analysis

In general terms the goal of child analysis is to enable the child to adapt itself to reality. Melanie Klein amplifies this when she writes:

If this has been successfully done the child's educational difficulties will be lessened, for it will have become able to tolerate the frustrations entailed by reality. Neurotic children do not tolerate reality well, because they cannot tolerate frustrations. They seek to protect themselves from reality by denying it or rejecting it.<sup>6</sup>

Full sexual enlightenment is also a consequence of a completed analysis. Without it no analysis can be said to have reached a successful termination.<sup>7</sup>

The third aim is "to strengthen the child's as yet feeble ego and help it to develop, by lessening the excessive weight of the super-ego."<sup>8</sup> All adherents of the psychoanalytic

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<sup>5</sup>H. Hartmann and E. Kris, "The Genetic Approach in Psychoanalysis", The Psychoanalytic Study of the Child, 1:18, 1945.

<sup>6</sup>Melanie Klein, The Psycho-analysis of Children (New York: Norton & Company, Inc. 1932) p. 34.

<sup>7</sup>Ibid., p. 35.

<sup>8</sup>Ibid., p. 214.

school maintain that a severe superego is the most important factor in arousing crippling anxiety and guilt.

The study of defence in infantile neurosis teaches us that the super-ego is by no means an indispensable factor in the formation of the neuroses. Adult neurotics seek to ward off their sexual and aggressive wishes in order not to come into conflict with the super-ego. Little children react to their instinctual impulses in the same way in order not to transgress their parents' prohibitions. The ego of the little child like that of an adult, does not combat the instinct of its own accord. Its defence is not prompted by its feelings in the matter. It regards the instinct as dangerous because those who bring the child up have forbidden their gratification and an irruption of instinct entails restrictions and the infliction of threat of punishment.<sup>9</sup>

A fourth aim is to alleviate the feelings of guilt and states of anxiety that characterize the neurotic child in face of a situation in which he feels his ego cannot stand the struggle between his id and superego. Lessening the severity of the superego will effect this, if along with it goes an interpretation of causes behind the illogical fears of the child.

Hence if the analytic situation is able to teach the child to tolerate frustrations and moderate the rigidity of the superego in conjunction with strengthening the ego in face of assaults from both the id and superego, feelings of guilt and states of anxiety will be minimized. The child will feel a newly gained freedom to express himself more adequately in outside activities.

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<sup>9</sup>Freud, The Ego and the Mechanisms of Defence, p. 60.



### Who Should Be Analyzed

"Child Analysis may well be restricted to the most severe cases of the infantile neurosis which every child experiences at one time or another before entering the latency period."<sup>10</sup> With this introductory statement, Anna Freud continues by listing and defining the factors which should determine the acceptance of a case for analysis.

1. The amount of neurotic suffering: The presence or absence of suffering cannot be considered a decisive factor. There are many serious neurotic disorders that children bear with equanimity because anxiety is warded off either by phobic or obsessional mechanisms. There are less serious ones that cause pain because acute neurotic suffering is felt by the child in all states of anxiety before a consistent defense against it has become established.

2. Disturbance of normal capacities: When imaginative play becomes repetitive and monotonous and interferes with all other kinds of activity, it is a sign that the child is fixated at a certain point of his libidinal development.

3. Disturbance of normal development: There is only one factor in childhood of such central importance that its impairment through a neurosis calls for immediate action, namely the child's ability to develop, not to remain fixated at some stage of development before the maturation process has been concluded.

4. Therefore child analysis should be used only in cases where there is slight or no hope for a spontaneous recovery...for infantile neuroses tend to disappear whenever the normal forward movement of the libido is strong enough to undo neurotic regression and fixation. When the libido constellations become rigid, stabilized and monotonous in their expressions the neurosis is in danger of

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<sup>10</sup>Freud, "Indications for Child Analysis", p. 131.

remaining permanently. This means that treatment is indicated.<sup>11</sup>

### Factors Determining a Favorable Prognosis

Since analysts feel that a rigid superego is the major factor in a neurosis it could be expected that Anna Freud would write as follows:

The prognosis for the solution of the psychic conflicts is most favorable when the motive for the ego-defence against instinct has been that of super-ego anxiety. Here the conflict is genuinely endopsychical and a settlement can be arrived at between the different institutions (id, ego, and super-ego) especially if the super-ego has become more accessible to reason through the analysis of the identifications upon which it is based and of the aggressiveness which it has made its own. The ego's dread of the super-ego having thus been reduced, there is no longer any need for it to resort to defensive methods, with pathological consequences.

Even when the ego-defence in infantile neurosis has been motivated by objective anxiety (due to a truly harsh environment) analytic therapy has a good prospect of success. The simple method - and that least in accordance with the principles of analysis - is for the analyst, when once he has been able to clarify the ego's defensive process for the child, to try so to influence reality, i.e. those responsible for the child's upbringing, that objective anxiety is reduced. Then the ego will adopt a less severe attitude toward the instincts and will not have to make such great efforts to ward them off.<sup>12</sup>

On the basis of these statements it would seem that no case would appear to be too obtuse or "deep" for child analysis. However, all writers of analytic procedure agree that

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<sup>11</sup>Ibid., pp. 136-141.

<sup>12</sup>Freud, The Ego and the Mechanisms of Defence, pp. 68-69.

the child must be able to express himself through play and indeed through words, to the extent of his ability, if the analysis is to reach completion. Therefore it seems to follow that any child who has rejected reality so completely that he cannot engage in either or both of these activities would not be accessible to the child analyst.

### The Therapeutic Situation

There is a split of opinion concerning the characteristics of the analytic situation. The Vienna School, typified by the writings of Anna Freud, hold that the therapeutic situation is characterized by a complete dependence of the child upon the analyst. From the very first interview she works to bring the child into an actual dependent relation.

I promise the little girl certain recovery.... I satisfy her evident desire to be guided by authority and to be cradled in safety. I offer myself openly as an ally and, in common with the child, I criticize the parents. In another case I begin a secret combat against the domestic environment and with all sorts of means strive for the love of the child. I exaggerate the seriousness of a symptom, and frighten the patient in order to attain my end. Finally I insinuate myself into the confidence of the children and thus obtrude myself on human beings who are of the conviction that they can get along very well without me.<sup>13</sup>

Melanie Klein adheres more closely to the traditional analytic situation.

With children, no less than with adults, the analytic

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<sup>13</sup>Freud, Introduction to the Technique of Child Analysis (New York: Nervous and Mental Diseases Pub. Co., 1928) p. 57.

situation can only be established and maintained so long as a purely analytic attitude is maintained towards the patient. I cooperate with the child, but I am careful to preserve the attitude of friendly reserve which seems as necessary for the establishment and maintenance of the analytic situation in child analysis as it is in the analysis of adults.<sup>14</sup>

### Therapeutic Techniques: Rapport

It follows from the above statements by Anna Freud in which she reveals her persistent efforts to woo the child that she believes that a close and intimate rapport must exist between analyst and patient before any real progress can be made. The patient must come to regard the analyst as a "person of undoubted power, whose authority is esteemed by the parents as greater than their own."<sup>15</sup> Bornstein takes a position almost as positive as Anna Freud's when she writes:

The child's distrust of the analyst has to be replaced by a positive relationship that will enable the child to sustain the trials of analysis. The analyst tries to change his external compliance into inner willingness; he tries to convey to him the insight he lacks. He follows the child's interests and participates in his activities and thus, with a minimum of direct questions, he is introduced into the child's world and is enabled to observe his attitudes and reactions.<sup>16</sup>

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<sup>14</sup>Klein, op. cit., p. 43n.

<sup>15</sup>Freud, Introduction to the Technic of Child Analysis, p. 17.

<sup>16</sup>Berta Bornstein, "Clinical Notes on Child Analysis", The Psychoanalytic Study of the Child, 1:152, 1945.

Melanie Klein again adheres more closely to the classical analytic technique which involves a more impersonal relationship between therapist and child. By maintaining an attitude of friendly reserve she is able to identify herself more closely with the child's past and thus develop a transference neurosis comparable to the similar technique employed in adult analysis.

To what an extent we can establish the analytic situation in treating children can be seen, for instance, from the fact that it is the exception for even the youngest ones to carry out exhibitionist actions in reality and that during periods of the strongest positive transference it very seldom happens that a child will climb on to my lap or kiss and hug me.<sup>17</sup>

#### Transference: Positive and Negative

The development of a transference neurosis is a technique of major importance in child as well as adult analysis. The classical definition of transference as taught by Sigmund Freud is rephrased by Anna Freud as follows:

By transference we mean all those impulses experienced by the patient in his relation with the analyst which are not newly created by the objective analytic situation but have their source in early - indeed, the very earliest - object-relations and are now merely revived under the influence of repetition-compulsion. There is the transference of libidinal impulses wherein the patient finds himself disturbed in his relation to the analyst by passionate emotions, e.g. love, hate, jealousy and anxiety,

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<sup>17</sup>Klein, op. cit., p. 44n.

which do not seem to be justified by the facts of the actual situation. They become comprehensible and indeed are justified if we disengage them from the analytic situation and insert them into some infantile affective situation.<sup>18</sup>

The transference of defence is characterized by a transfer of the id-impulses in all those forms of distortion which took shape while the patient was still in infancy.<sup>19</sup>

Melanie Klein maintains this classical position in her work with children. She feels that she does not have to work to develop the transference because it occurs rather spontaneously in the child.

In these pages emphasis has repeatedly been laid upon the child's capacity for making a spontaneous transference. This is to some extent due, I think, to the much more acute anxiety which it feels in comparison with the adult and consequently its greater degree of apprehension. One of the greatest, if not the greatest psychological task which the child has to achieve, and which takes up the larger part of its mental energy, is the mastering of anxiety. Its unconscious is therefore primarily interested in objects from the point of view of whether they allay anxiety or excite it; and according as they do the one or the other it will have a positive or a negative transference towards them.<sup>20</sup>

Following through her intention to establish strong positive feelings between herself and her patient, Anna Freud believes that progress cannot be made until a positive transference has been developed and any negative transference

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<sup>18</sup>Freud, The Ego and the Mechanisms of Defence, p. 18.

<sup>19</sup>Ibid., p. 20.

<sup>20</sup>Klein, op. cit. p. 50.

has been removed.

We know that with adults we can get along over long periods with a negative transference, which we make use of for our purpose by means of consistent interpretation and reference to its origin. But with the child the negative impulses directed against the analyst - no matter how revealing they may be in many respects - are above all unpleasant. As soon as possible we must seek to weaken and destroy them. The actual productive work will always go hand in hand with a positive attachment.

The affectionate attachment, the positive transference as the analytical term is, is the prerequisite for all subsequent work. In this the child goes even further than the adult, for it has faith only in the person it loves and then accomplishes something only out of love for that person.<sup>21</sup>

In fact Anna Freud goes so far as to hold that "the child does not develop a transference neurosis in the strict sense. There is no need for him to repeat his reaction vicariously since he still possesses his original love-objects, his parents, in reality."<sup>22</sup>

### Catharsis

The aim of the transference technique is to develop a relationship between analyst and patient whereby distorted or displaced emotions can be released. Such destructive emotional responses are associated with repressed instinctual urges, and in many cases arise in the neurotic when a situation similar to the precipitating incident is encountered.

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<sup>21</sup>Freud, Introduction to the Technique of Child Analysis, p. 34.

<sup>22</sup>Ibid., p. 37.

The analysts maintain that in the transference relationship they can release these emotions by interpretations of the situation which will permit the analysand to recognize the amount of displacement and distortion he has permitted himself. When the patient does gain this insight, then the unconscious tendencies are deprived of most of their power.

Relegated to the unconscious, these instinctual urges are out of reach; uncovered, and lifted to the conscious level they automatically come under the patient's control and can be dealt with according to his ideas and ideals.<sup>23</sup>

Anna Freud holds with Lippman that emotional release should proceed slowly.

There is danger in getting too much anxiety material early in the treatment. The child stimulated by telling his dream may plunge prematurely into a discussion of facts that he may later regret having disclosed; he may even feel he had been tricked into telling things that he wanted to keep secret.<sup>24</sup>

On this point Melanie Klein takes a more radical position.

If we have an eye to the full urgency of the material presented, we find ourselves obliged to trace not only the representational content but also the anxiety and sense of guilt associated with it right down to that layer of the mind which is being activated. But if we model ourselves on the principles of adult analysis and proceed first of all to get into contact with the superficial strata of the mind - those which are nearest to the ego and to reality - we shall fail in our object of establishing the analytical situation and reducing

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<sup>23</sup>Freud, "Indications for Child Analysis", p. 128.

<sup>24</sup>Hyman S. Lippman, "The Use of Dreams in Psychiatric Work with Children", The Psychoanalytic Study of the Child, 1:238, 1945.



anxiety in the child.<sup>25</sup>

She offers rather specific methods for handling the analysis when strong emotion breaks through:

There are three ways in which analytic technique deals with a child's outbreaks of emotion during treatment:

(1) The child has to keep part of its affect under control, but it should only be required to do so in so far as there is a necessity for it in reality:

(2) It may give vent to its affects in abuse and other ways: and

(3) Its affects are lessened or cleared up by continuous interpretation and by tracing back the present situation to the original one.<sup>26</sup>

### Interpretation

Perhaps the outstanding and most widely recognized technique of analysis is that of daily systematic interpretation. In order to obtain the material concerning the ego defenses and the id-impulses that are a prerequisite for accurate interpretations which will be accepted by the patient because they are compatible with the structure of his psyche, the classical analyst employs the method known as free association. With the adult it presupposed a therapeutic situation wherein the ego of the patient was held in abeyance so that the id could freely express itself in the verbalizations that expressed the immediate consciousness of the client as he relaxed on the analytic couch.

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<sup>25</sup>Klein, op. cit., p. 52.

<sup>26</sup>Ibid., p. 89.

Young children are neither willing nor able to embark on free association. Children placed on the analytic couch for the purpose of relaxed concentration are usually completely silenced. Talk and action cannot be separated from each other in their case. According to the technique (developed by Melanie Klein) the child's spontaneous play activity with small toys offered by the analyst for free use within the analytic hour was substituted for free association. The individual actions of the child in connection with this material were considered to be equivalent to the individual thoughts or images in a chain of free association.<sup>27</sup>

The dreams and day-dreams of children, the activity of their phantasy in play, their drawings and so forth reveal their id-tendencies in a more undisguised and accessible form than is usual in adults, and in analysis they can almost take the place of the emergence of id-derivatives in free association.<sup>28</sup>

In making these interpretations the analysts are aware of the language of the id, and define the symbolic representations according to the guide outlined by Sigmund Freud, as a result of his work in dream-interpretation.

One by-product of dream-interpretation, namely, the understanding of dream-symbols, contributes largely to the success of our study of the id. Symbols are constant and universally valid relations between particular id-contents and specific ideas of words or things. The knowledge of the language of symbols has the same sort of value for the understanding of the id as mathematical formulae have for the solution of typical problems.<sup>29</sup>

At what time in the course of analysis interpretation should begin has been the subject of a controversy between

<sup>27</sup>Freud, "Indications for Child Analysis", p. 129.

<sup>28</sup>Freud, The Ego and the Mechanisms of Defence, p. 40.

<sup>29</sup>Ibid., p. 16.

the Vienna and London groups of child analysts. Melanie Klein speaks for the latter when she writes:

As soon as the small patient has given me some sort of insight into his complexes - whether through his games or his drawings or phantasies, or merely by his general behaviour - I consider interpretation can and should begin. This does not run counter to the well-tried rule that the analyst should wait till the transference is there before he begins interpreting, because with children the transference takes place immediately, and the analyst will often be given evidence straight away of its positive nature. But should the child show shyness, anxiety or even only a certain distrust, such behaviour should be read as a sign of negative transference, and this makes it still more imperative that interpretation should begin as soon as possible.<sup>30</sup>

Anna Freud and her followers in the United States maintain that interpretation should proceed slowly.

The multiplicity of meanings in a child's play is likely to lead to misinterpretations. Without a thorough knowledge of the child's past and present situations play cannot be fully understood.... The most effective way to stop a child from telling his dreams is to try early to explain or interpret their content to him; this applies especially to dreams that reflect hostility or sexual conflict. It becomes apparent to him that dreams reveal secrets and it is therefore dangerous to tell them. He may go away from the interview more anxious and disturbed than when he came, and thus be conditioned against the treatment.<sup>31</sup>

At what level of the psyche the interpretations should be directed has also been the subject of much disagreement between the two schools of analysts. Hartmann and Kris, in

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<sup>30</sup>Klein, op. cit., p. 46.

<sup>31</sup>Hyman S. Lippman, "The Use of Dreams in Psychiatric Work with Children", The Psychoanalytic Study of the Child, 1:235, 1945.

agreement with Anna Freud state that "interpretation should start as close as possible to the experience of the patient - at the higher layers - and elucidate the structure of defenses before they proceed to what stems from the id."<sup>32</sup> Anna Freud believes in working from the surface downward and in unraveling the conscious anxieties in order to disentangle the unconscious. She adheres to the principle that the symptoms of the neurosis are not manifestations of the id-impulses, but rather the intervention of the ego. She describes these external symptoms as ego-defenses. In particular she believes that in an attempt to repress the id-impulses the ego will distort the external manifestations of the child's affects. Therefore:

The analysis and bringing into consciousness of the specific form of this defence against affect - whether it be reversal, displacement or complete repression - teaches us something of the particular technique adopted by the ego of the child in question and just like the analysis of resistance, enables us to infer his attitude to his instincts and the nature of his symptom formation.<sup>33</sup>

Hence it can be fairly stated that the Vienna School adheres to the principle of interpreting the ego-defenses first and then, only when this has been carefully and thoroughly done, attacking the manifestations of the id-impulses.

Melanie Klein tries to reach the lowest depth of anxiety with the first interpretation in the belief that this is es-

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<sup>32</sup>Hartmann and Kris, op. cit., p. 15.

<sup>33</sup>Freud, The Ego and the Mechanisms of Defence, pp.41-42.

essential in order to relieve the anxiety. This statement is corroborated by many pages in the second chapter of her book. The following excerpts indicate what she maintains is of greatest importance in making effective interpretations:

A correct and rapid estimation of the significance of that material, both as regards the light it throws on the structure of the case and its relation to the patient's affective state at the moment, and above all a quick perception of the latent anxiety and sense of guilt it contains - these are the primary conditions for giving a right interpretation, i.e. an interpretation which will come at the right time and will penetrate to that level of the mind which is being activated by anxiety.<sup>34</sup>

The form in which interpretation is given is another thing of great importance. It should be modelled on the concrete way in which children speak.... We have occasion to see over and over again that children have a quite different attitude from adults to words. They assess them above all according to their imaginative qualities - to the pictures and phantasies they evoke. If we want to gain access to the child's unconscious in analysis we shall only succeed if we avoid circumlocution and use plain words.<sup>35</sup>

### Resistance

All psychotherapists have to consider carefully the problem of resistance, which if it becomes strong enough can prevent the patient from making use of the therapeutic situation. It can be defined as an overt manifestation of the ego's defensive operations against repressed instincts

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<sup>34</sup>Klein, op. cit., p. 58

<sup>35</sup>Ibid., pp. 60-61n.

entering consciousness.<sup>36</sup> Anna Freud uses every device to break down any initial resistance, such as structuring the analytic situation in the following terms: "The parents can do nothing with you.... With their help alone, you will never get away from these constant scenes, and conflicts. Perhaps you will try once more with a stranger."<sup>37</sup> Or she will enter into the child's play, do little favors that please him or even give him small gifts.

In contrast, Melanie Klein regards initial resistance as a manifestation of anxiety associated with negative transference; and following her original concept that correct interpretation relieves the ego from maintaining its defenses against release of the id-material, she uses interpretations to remove resistance.

Where a negative transference is uppermost from the first, or where anxiety or resistances begin to appear at once, we have already seen the absolute necessity of giving interpretations as soon as possible.<sup>38</sup>

This same technique of interpretation is utilized by both groups of child analysts to meet periodic breaks in free association and play.

If we analyze the interruptions to play, we discover that it represents a defensive measure on the part of the ego, comparable to resistance in free association.

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<sup>36</sup>Freud, The Ego and the Mechanisms of Defence, p. 32.

<sup>37</sup>Freud, Introduction to the Technic of Child Analysis, p. 35.

<sup>38</sup>Klein, op. cit., p. 51.

A child's play is equivalent to the associations of adults and we can make use of his games for purposes of interpretations in just the same way.<sup>39</sup>

### Education

In her writings, Anna Freud sets up a duality of function for the child analysts.

The analyst combines in his own person two difficult and diametrically contradictory tasks; that is, he must analyze and he must educate, must in one breath permit and forbid, loosen and hold in check again. If he does not succeed in this, the analysis will be a charter for all the bad habits banned by society. If he does succeed he makes retrogressive a bit of missed education and abnormal development and provides for the child, or for whomever decides the fate of the child, the possibility of once more improving its behavior.<sup>40</sup>

We can say in short: during the course of the analysis the analyst must succeed in putting himself in place of the ego-ideal of the child and he must not begin his analytical work of liberation before he is certain that he can completely control the child at this point.<sup>41</sup>

On this point, Klein takes an opposite view from the one expressed above. She maintains that the analytic situation is an opportunity to interpret the ego defenses and id-impulses so that the patient can make a reorientation to reality. She does not believe that it is compatible with the role of the classical analyst for her to install herself as a temporary ego-ideal in order to keep the child's acti-

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<sup>39</sup>Freud, The Ego and the Mechanisms of Defence, p. 41.

<sup>40</sup>Freud, Introduction to the Technic of Child Analysis, p. 55.

<sup>41</sup>Ibid., p. 51.

vities acceptable to his social group.

I may remark that in this particular case, where the evil consequences of the boys' relations were so striking, I did not find it at all easy to keep to my absolute rule of abstaining from any interference of that kind. And yet it was precisely this case which brought me most convincing proof of the uselessness of any educational measures on the part of the analyst. Even if I had been able to stop their practices - which I was not - I should have done nothing towards the essential business of removing the underlying determinants of the situation and thus giving a new direction to the whole course of their hitherto faulty development.<sup>42</sup>

### Role of the Child

Because of his inferior status, the child is not the one who initiates the analysis. The child is not asked for his consent. Even if the question should be put to him, he wouldn't be able to form an opinion concerning the efficacy of analysis.<sup>43</sup> Anna Freud maintains, then, that it is the function of the parent rather than the child to initiate analysis. However, once the analysis is under way, she works to establish a will and decision to be cured. In establishing rapport she remarked to one young patient that two of her friends were coming for help with their bad habits. When the patient replied, "I have a devil in me. Can it be taken out?", Anna Freud said that she thought she could in time, if the patient would cooperate.<sup>44</sup> From that point on,

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<sup>42</sup>Klein, op. cit., p. 171n.

<sup>43</sup>Freud, Introduction to the Technic of Child Analysis, p. 3.

<sup>44</sup>Ibid., p. 5.



the child worked to free herself from her devil.

Melanie Klein believes too that the analysis proceeds more rapidly with the cooperation of the child. She attributes the instigation of cooperation not so much to a will and decision to be cured, as she does to the immediate relief felt when small amounts of anxiety have been resolved by interpretation.

Whereas he has hitherto had no incentive to be analyzed, he has now got an insight into the use and value of such a procedure, and an insight of a kind which will be quite as effective a motive for being analyzed as is the adult's insight into his illness.<sup>45</sup>

In cases where the parents had some understanding concerning the aims and length of therapy, it was possible for a patient of Anna Freud to persuade his parents to continue therapy when their hopes were lagging.<sup>46</sup>

The analysts offer the child freedom in the choice of toys so that he does determine to some extent the course of his play. However, they recognize that any interpretations they make will influence the continuity if not the type of play.

#### Role of the Therapist

It is the function of the therapist, once therapy has

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<sup>45</sup>Klein, op. cit., p. 33.

<sup>46</sup>Freud, Introduction to the Technic of Child Analysis, p. 6.

been started to diagnose the difficulty and select the techniques that appear most profitable. Both Anna Freud and Melanie Klein were adapting the classical techniques of adult analysis to their work with children, but they held it was the duty of the therapist to develop rapport, and a "transference neurosis", facilitate catharsis, and meet resistance. The Vienna School adheres to the basic rule that interpretation of the ego defenses will enable the therapist to effect these dynamic situation; whereas the London School believes that early and deep interpretation will bring about the same results. However, both groups maintain that these are the functions of the analyst, and that the ease and rapidity which will be characteristic of a particular case depend partly upon the type of difficulty and partly upon the skill of the analyst.

Melanie Klein always imposes the conditions of time and place upon her patients and even refuses to let the person who brings the child to analysis wait in her house. "In that way the analysis remains, as it should, a purely personal matter between myself and my patient."<sup>47</sup>

Maintaining her position that the analyst must build up a very close and intimate relationship with the child, Anna Freud does not confine her interviews to her office, but believes it is correct to visit the patient in his home.<sup>48</sup>

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<sup>47</sup>Klein, op. cit., p. 113.

<sup>48</sup>Freud, Introduction to the Technic of Child Analysis, p. 35.

Probably the outstanding functions of the child analyst as defined by Anna Freud, are the production of insight into the development of the illness, the establishing of a strong affection for the therapist, and the temporary substitution of the analyst for the weak ego-structure of the child.

"The ability of the child to be analyzed goes hand in hand with producing an insight into the illness."<sup>49</sup>

Concerning the other two functions she writes:

The affectionate attachment, the positive transference as the analytical term is, is the prerequisite for all subsequent work. In this the child goes even further than the adult, for it has faith only in the person it loves and then accomplishes something only out of love for that person.<sup>50</sup>

We may say in short: during the course of the analysis the analyst must succeed in putting himself in place of the ego-ideal of the child and he must not begin his analytical work of liberation before he is certain that he can completely control the child at this point.<sup>51</sup>

Klein seems to maintain that the chief functions of the child analyst revolve around deep, rapid, and correct interpretation and the catharsis of affects in a therapeutic situation that is kept impersonal. Mention has been made earlier concerning her antipathy about arousing a strong positive attachment between herself and the child. Likewise several quotations have been made under the section concerning interpretation about her insistence upon constant and

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<sup>49</sup>Ibid., p. 12.

<sup>50</sup>Ibid., p. 34.

<sup>51</sup>Ibid., p. 51.

consistent use of this particular technique.

The analysts insist on daily interviews, excepting where illness or vacations prevent them. They hold that it is their privilege to indicate the termination of treatment because only a specialist can realize when the psychic structure has been truly reorganized. However, when the parents insist on termination, they have no alternative but to acquiesce, for the parents control the payment of fees.

### Role of the Parent

Insight into the seriousness of the neurosis, the decision to begin, and to continue treatment, persistence in the face of resistance or of passing aggravations of the illness are beyond the child and have to be supplied by the parents. In child analysis the parents' good sense plays the part which the healthy part of the patient's conscious personality plays during an adult analysis to safeguard and maintain the continuance of treatment.<sup>52</sup>

With these words Anna Freud describes the duties of the parents during an analysis of their child. In fact she goes so far as to write:

Child analysis belongs above all in the analytic milieu and must provisionally be limited to the children of analysts, of analyzed patients, or parents who contribute to analysis a certain trust and respect. Only here will analytic education during treatment allow itself to be transferred to home education without a break. Where analysis of the child cannot be organically one with other living conditions, but, like a foreign body is injected into other relationships which are thereby disordered, one will probably create for the child more conflicts than treatment in the other direction will be able to dissolve.<sup>53</sup>

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<sup>52</sup>Freud, "Indications for Child Analysis", p. 129.

<sup>53</sup>Freud, Introduction to the Technique of Child Analysis, p. 56.

Other child analysts do not take such a strong stand. Representative of the American analysts, Lippmann feels it is the analyst's duty to help the parents to understand the nature of treatment and prepare them for aggression and hostility. At the end he instructs them in avoidance of the behavior that contributed to the neurosis.

Klein feels that there has to be a relation of confidence between the analyst and the child's parents. She expects the parents to feel a sense of guilt for their child's neurosis, and a jealousy on the part of the mother because the analyst is receiving the confidence and some positive feelings from the child. However, she does not believe that they have to be analyzed, for she has met with no less hindrance where the parents were familiar with analysis than where they knew practically nothing about it.

I consider any far-reaching theoretical explanations to the parents before the beginning of an analysis as not only unnecessary but out of place, since such explanations are liable to have an unfavourable effect upon their own complexes. I content myself with making a few general statements about the meaning and effect of analysis, mention that, in the course of it, the child will be given information upon sexual subjects and prepare the parents for the possibility of other difficulties arising from time to time during the treatment. In every case I refuse absolutely to report any details of the analysis to them. The child who gives me its confidence has no less claim to my discretion than the adult.<sup>54</sup>

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<sup>54</sup>Klein, op. cit., p. 117.

### Summary

The child analysts adhere to the classical structure of psyche and neuroses as defined by Sigmund Freud. The Vienna School, as explained in the writings of Anna Freud, believe that there is some departure from the classical techniques of adult analyses, for a true transference neurosis and free association are not possible for the child. However, they make interpretation of the ego-defenses and id-impulses the core of their therapy. Anna Freud, in particular, associates with this a strong affectionate tie between herself and the child and a relationship in which the analyst has so much authority that the child looks to her for guidance and ego control.

The London group, headed by Melanie Klein, adheres more closely to the impersonal relationship of the classical analytic situation. They anticipate strong negative and positive feelings in the analytic hour, which they meet with constant and consistent interpretation of the id-impulses. They maintain that while the analytic situation is impersonal in that the analyst is a sounding-board for the thoughts and affects of the child, nevertheless it is a confidential relationship between patient and analyst that permits no betrayal, even to the parents.

## CHAPTER III

### RELATIONSHIP THERAPY

Among the European analysts who were actively practicing during the period of the first World War and the decade following, was one who influenced strongly the group of child therapists who came to be known as adherents of relationship therapy. This analyst, Otto Rank, wrote copiously concerning his thought of human life, its beginnings, growth, adjustments and endings. According to Jessie Taft, who translated his book Will Therapy, "Otto Rank above all others has understood the psychology and philosophy of helping without which no therapy can succeed except by chance."<sup>1</sup> Therefore many of the concepts basic to this type of therapy stem from the theories developed by Otto Rank; and while there is much material that could be classified as Freudian, these concepts have a new structure oriented around this philosophy of whole versus part and sequences of beginnings and endings.

#### Basic Concepts

Both Jessie Taft and Frederick Allen endeavor to have it clearly understood that they do not hold with the

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<sup>1</sup>Jessie Taft, The Dynamics of Therapy in a Controlled Relationship (New York: The Macmillan Company, 1933), p. viii.

Freudian practice of concentrating on past events and that they do not feel that they can effect any change merely through the role of doctor and patient. In fact they adopt the term therapist because it is derived from the Greek noun which means "a servant".

I wish to use the English word "therapy" with the full force of its derivation, to cover a process which we recognize as somehow and somewhat curative but which, if we are honest enough and brave enough, we must admit to be beyond our control.... No one wants another to apply any process to the inmost self, however desirable a change in personality and behavior may seem objectively.... I know in advance that no one is going to experience change, call it growth or progress if you have courage, because I think it would be good for society, good for his family and friends or even good for himself. I know equally well that no one is going to take help from me because someone else thinks it is desirable. The anxious parent, the angry school teacher, the despairing wife or husband, must bear their own burdens, solve their own problems. I can help them only in and for themselves, if they are able to use me.<sup>2</sup>

In conjunction with the acceptance of the therapeutic role of "waiting to help" rather than actively curing, they adopted from Rank and the Gestaltists the concept of the development of parts from wholes. In the words of Allen, the process is called individuation.

Individuation is, by its very nature, a differentiating process. As a social and biological phenomenon, it stands in the center of the growth picture and constitutes its essence.<sup>3</sup>

Growth...is a biological process occurring within a

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<sup>2</sup>Ibid., p. 3.

<sup>3</sup>Frederick Allen, Psychotherapy with Children (New York: W.W. Norton & Company, Inc., 1942), p. 45.



framework of relationships and events which gives meaning and direction to the emerging self of the child. This emerging self is not a pawn moved around by external influences designed to restrict the primal instinctive forces; in that point of view there is little place for the real and spontaneous values of the self. These outer and inner forces are, instead, a totality, and the child acquires through their operation a feeling of what belongs to self and what belongs to the outer world in which he experiences his capacities.<sup>4</sup>

The vitalizing quality in the infant receives its first meaning and direction through being experienced within this framework of a living reality with others who can allow its different value and, at the same time, guide and limit its expressions in the child role. In this manner the child learns he does not exist as a total force in himself. By the very nature of life he feels his strength in relation to another person usually stronger and always different from him.<sup>5</sup>

Thus if one accepts the Rankian principles that all life is a series of relationships which are characterized by a continuous process of separation from the source and resultant crystallization of individual characteristics, one will arrive at the following description of therapy.

Therapy occurs through a unique and purposeful relationship between patient and therapist. Just as growth is the differentiation of live individuals from each other so therapy is a unique growth experience in which the patient differentiates himself from the therapist. Children always develop within a relationship.<sup>6</sup>

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<sup>4</sup>Ibid., p. 42.

<sup>5</sup>Ibid., p. 24.

<sup>6</sup>Frederick H. Allen, "Areas of Agreement in Psychotherapy", The American Journal of Orthopsychiatry, 10:698, October 1940.

### Aims of Therapy

It seems that the relationship therapist offers the patient an opportunity to live through an experience that brings into clear focus the possibilities and limitations of life. If the child is able to make use of the situation and therapist, he will gain some understanding of the relative value of the present and his need to move on into the future. In order to obtain this insight into life, the child must come to perceive and accept his own self as separate and distinct from the therapist. "The child experiences fear when he leaves the old and undertakes to be part of the new. One should not protect him from his fear but support him in it."<sup>7</sup>

The individual finally learns to utilize the allotted hour from beginning to end without undue fear, resistance, resentment or greediness. When he can take it and also leave it without denying its value, without trying to escape it completely or keep it forever, because of this very value, in so far as he has learned to live, to accept his fragment of time in and for itself, and strange as it may seem, if he can live this hour he has in his grasp the secret of all hours, he has conquered life and time for the moment and in principle.<sup>8</sup>

### Who Can Be Helped

In order to receive any help from this type of therapy a child must be able to establish a relationship with the therapist.

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<sup>7</sup>Ibid., p. 699.

<sup>8</sup>Taft, op. cit., p. 17.

A child can hold himself aloof from establishing any relationship with a therapist, and, by doing that, allow nothing positive to get into this experience. If he continues to maintain the projection of all the curing force on the therapist, nothing will happen in the therapy and the child may end right where he begins.<sup>9</sup>

Hence it follows that any child whose resources are so meager that he cannot establish contact with the individuals in his environment is not suitable for this psychotherapeutic method. In addition the child must be able to assume responsibility for his own growth and individuation, if he is to gain anything. Some children are so satisfied with their complete absorption by the mother figure that they neither desire to begin the process of separation nor have the courage to do so.

The fearful, self-conscious, cautious child, the so-called "neurotic in embryo", is far more suited to relationship therapy than an impulsive child who rushes into blind action to relieve himself regardless of the other person.<sup>10</sup>

Therefore, for a good prognosis, it is preferable that the child's impulses be organized sufficiently so that he is aware of the inherent destructiveness of these impulses in their initial stages. He must be willing to inhibit them "without denial of their import before they have plunged him into overt behavior which he has not chosen with

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<sup>9</sup>Allen, Psychotherapy with Children, p. 243.

<sup>10</sup>Taft, op. cit., p. 119.

his total self or which is too extreme for the therapist to accept."<sup>11</sup> In more Freudian terms, which the relationship therapists strive to avoid, the child must have a fairly well-defined superego and ego structure and the ability to establish rapport with an individual for there to be much hope of obtaining results from this type of therapy.

### The Therapeutic Situation

According to the above concepts, the therapeutic situation is different from a real life situation in that it points up the dynamics of the conflicts and ambivalences of living.

The dynamic value of the immediate experience is to unburden the individual from those parts of his past which for him were destructive, and to help him affirm certain positive values in that past which he may have denied.... The emphasis centers about what he can begin to do as anxieties are stirred in this new relationship, and in how he can acquire attitudes about himself that will enable him to be free of these disorganizing feelings. When he finds he can live through the fear roused by this new reality he has begun to travel the road toward greater freedom to be himself. And the only thing a therapist can do for anyone in a therapeutic experience is to help that person gradually to be himself, to help him gain a sounder evaluation of his own difference and the consequent freedom to make creative, responsible use of that difference in the continuing realities of his life.<sup>12</sup>

According to Taft, the relationship is taken simply and immediately for itself and is developed according to what the child finds in it and can do to it "of her own will

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<sup>11</sup>Loc. cit.

<sup>12</sup>Allen, Psychotherapy with Children, p. 54.

both positively and negatively, under the pressure of the deprivations and frustrations imposed by the time limits, the reality situation, and the lack of projection on the part of the therapist."<sup>13</sup>

Thus it can be stated that relationship therapy is child-centered in that there is no desire to force the child into a preconceived structure and thus reorganize his psyche according to the demands of the environment. However, the therapeutic situation must conform to the basic laws of life; and as this group understand them, they are the laws of time and limits.

Time represents more vividly than any other category the necessity of accepting limitation as well as the inability to do so, and symbolizes therefore the whole problem of living. The reaction of each individual to limited or unlimited time betrays his deepest and most fundamental life pattern, his relation to the growth process itself, to beginnings and endings, to being born and to dying.... In terms of the primary double fear of the static and of the endlessly moving, the individual is always trying to maintain a balance, and frequently fails because of too great fear either of changing or of never being able to change again.<sup>14</sup>

The fixed and static fact of time takes on dynamic meaning through the struggle the child puts into controlling it. It may seem arbitrary to those who have not worked with children to hold to a time schedule. However, a known situation provides an important opportunity for the child to struggle against the control of the real limits imposed by this new experience. While these limits are defined by the therapist, they are not a personal exercise of power. A therapist who accepts

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<sup>13</sup>Taft, op. cit. p. 27

<sup>14</sup>Ibid., p. 12

fully the responsibility implicit in his role must give definition to that role by holding the child to the limits which in reality, are binding both upon him and upon the child. There is real meaning in helping a child to bring into the open the feeling aroused in him by his encountering a limit.<sup>15</sup>

In addition to the time limits, there are those that center around the inviolability of the person of the therapist and restrictions concerning the use of equipment. According to Allen, such limitations are absolutely essential to the framework of the therapeutic relationship.

Children become frightened when, from the adult world, there are no controls set to their emerging sense of power. They need the steadiness and comfort of an authority which provide a backlog against which they can gain a sense of their own power.<sup>16</sup>

### Therapeutic Techniques

In following Rank and breaking from classical Freudian technique, this group of therapists also discard the classical terminology, such as rapport, transference and catharsis. However, under the guise of a new label, some of the same techniques are employed.

### Rapport or Positive Relationship

According to Lowrey, the major function of the therapist is to enable the child to recognize his feelings with a person

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<sup>15</sup>Allen, Psychotherapy with Children, p. 207.

<sup>16</sup>Ibid., p. 106.

who is able to accept them and explain them, yet at the same time impose limitations and restrictions.<sup>17</sup> Taft believes that if the therapist truly recognizes her inability to change the child and his capacity to use her to effect individuation and growth, a positive relationship will always develop, provided the case has been properly chosen.<sup>18</sup>

Blanchard who feels as strongly as the others that the relationship between child and adult is absolutely essential for therapy, maintains that in some cases the positive relationship develops rather slowly. However, she writes:

It is a vital step in the development of a relationship, for very often the child needs to verbalize affectionate feelings toward the therapist before being able to express aggressive or angry ones. Often there is less anxiety and guilt over loving attitudes, but once able to express them, the aggressive ones can be dared more easily.<sup>19</sup>

### Transference

The relationship therapists, with the exception of Taft, do not use the concept of transference to describe any part of their technique. As Taft describes the Rankian concept of classical transference, it becomes a description of strong positive rapport rather than the process of pro-

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<sup>17</sup>Lowrey, Allen, et al., "Symposium on Play Therapy", The American Journal of Orthopsychiatry, 8:511, July 1938.

<sup>18</sup>Taft, op. cit. p. 5.

<sup>19</sup>Phyllis Blanchard, "Case of Henry Brooks", Psychiatric Interviews with Children (New York: The Commonwealth Fund, 1946) p. 353n.

jecting upon the therapist strong positive or negative emotions that seem distorted in view of the present therapeutic situation. However, in line with her statement above, she writes that a strong positive relationship is the core of therapy.

The reason why these experiences in relationship which I have called therapeutic, work healingly for the individual, is that there is present always in every human being underneath the fear, a powerful, more or less denied, unsatisfied impulse to abandon the ego defenses and let the too solid organization of the self break up and melt away in a sense of organic union with a personality strong enough to bear it and willing to play the part of the supporting whole.<sup>20</sup>

Transference...is a stage in the growth process, in the taking over of the own will into the self. It is the point at which the will is yielded up to the other and kept in abeyance in the self. Inevitably, as inevitable as life goes on of its own impulse, this transference projection will flow back into the positive will of the patient and be acknowledged as his own.<sup>21</sup>

Allen does not believe that such a strong emotional response develops between child and therapist. He recognizes that the patient will show positive as well as negative feelings during the process of therapy; but these develop according to the patterns of response that the child has grown to use in meeting the life processes of beginnings and endings. Since the neurotic child is afraid of all beginnings because they require a separation from life as it was and a partial loss of self, he will be afraid

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<sup>20</sup> Tart, op. cit., p. 289.

<sup>21</sup> Ibid., p. 97.



of the therapeutic situation. Then instead of working for a strong positive transference, the therapist provides support for the child in his efforts to deal with the reality of this new experience.<sup>22</sup>

### Expression of Feeling

Freedom of expression is another important characteristic of the therapeutic situation. The child is helped through the skill and understanding of the therapist to express his emotional reactions to the therapeutic situation whether they be positive or negative.

The therapist must be a barometer, sensitive to the least change in the therapeutic atmosphere, removed enough from personal necessity for this particular hour to use his more conscious and more reliable feeling reactions to bring the patient to a deeper realization and tolerance of his own.<sup>23</sup>

Following Rankian philosophy closely, Taft strives for expression and recognition of the inherent ambivalence of each child, "that human capacity for wanting and not wanting the same thing at the same moment, and the bi-polarity of fear, the fear of becoming a separate individual and the fear of dying without having lived."<sup>24</sup> Therefore if she would adhere to Freudian terminology, she would write that catharsis of fear and anxiety affects is absolutely

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<sup>22</sup>Allen, Psychotherapy with Children, p. 91.

<sup>23</sup>Taft, op. cit., p. 118.

<sup>24</sup>Ibid, p. 103.

essential for successful therapy.

Allen breaks more sharply with the analysts, and would insist that his technique be labelled "expression of feeling" rather than catharsis; for he believes that although the fear and anxiety responses have become a part of the child's reactions to living relationships, the emotions that are recognized are those of the present situation and not of his past.

The anxiety that has locked these two people together destructively was activated again in the child's first therapeutic hour but now with a person who was able to help him admit his fear and to begin doing something about that fear. It is true that there was little verbal content that connected this fear to his past life, and therefore no delving into causes by reaching back into that past. Indeed the opposite was true. The interest and focus were on the present, living boy, and on the feeling content of the hour. It was the immediate experience that brought into the foreground the disturbance of feeling that made help necessary, and enabled this new relationship, even in the one therapeutic hour, to take on significance for both boy and mother.<sup>25</sup>

### Interpretation

Allen breaks as definitely with the classical understanding of interpretation as he does with their concept of catharsis. Rather he would employ the term "clarification of feeling and content". "Therapy begins when the therapist is brought into a relationship as a supporting and clarifying influence around the patient's need and desire to gain

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<sup>25</sup>Allen, Psychotherapy with Children, p. 77.

or regain a sense of his own worth."<sup>26</sup> In an atmosphere of acceptance and permissiveness the child is encouraged to talk about his feelings concerning the therapeutic situation and any material or affects of his past that seem important to him.

I want to make it clear at this point that because a therapist is oriented to the value of the immediate experience this in no sense means that he must try to make the patient forget the past and talk only of what goes on between them. But I do want to stress the fact that the therapist who can be sensitive to the uses a patient is making of the past in this present experience will be one who can exercise real therapeutic (i.e. "healing") influence and help the patient come, as it were, up to date with himself.<sup>27</sup>

Allow the patient to understand himself in the immediate experience which permits living and understanding to become one where, for the first time, we find a striving for an immediate understanding of experience, consciously, in the very act of experiencing.<sup>28</sup>

Taft writes that she doesn't interpret, but verbalizes:

Interpretation there was none, except a verbalization on my part of what the child seemed to be feeling and doing, a comparatively spontaneous response to her words or actions which should clarify or make more conscious the self of the moment whatever it might be.<sup>29</sup>

Blanchard does more true interpreting than any of the others, but she cautions that it must be done very slowly, with an orientation toward the immediate situation rather

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<sup>26</sup>Ibid., p. 47.

<sup>27</sup>Ibid., p. 51.

<sup>28</sup>Ibid., p. 52.

<sup>29</sup>Taft, op. cit., p. 28.

than the past.

Aggression could be permitted only in a very indirect way, disguised in phantasies. I gave no interpretation, since his use of phantasy indicated that he still needed to disguise his feelings. At this moment, interpretation would have caused too much anxiety and would have tended to reinforce the repression rather than relax it.<sup>30</sup>

### Acceptance and Permissiveness

The relationship therapists employ constantly two techniques that are mentioned by the child analysts but which are considered of secondary importance. These are labelled "acceptance" and "permissiveness" by the writer in accordance with the terms used by the non-directive group. Certainly in their writings Allen and Taft imply these terms in describing their methods; for Allen says:

The child is immediately placed in the center of a relationship that is significant because of its uniqueness. It is unique because he finds a person who is able to accept him just as he is. If he is angry, he can be helped to experience the full surge of that feeling. If he is fearful, the child has the support of a person who can understand his need to be afraid and who does not immediately try to reassure him in order to take that feeling away. He comes expecting to be changed and ready to fight or protect himself against the power of this strange, unknown person. Instead, he finds a person who is interested in him as he is.<sup>31</sup>

Blanchard reiterates Allen's thoughts in concise terms.

The therapist has to preserve an impersonal attitude,

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<sup>30</sup>Blanchard, op. cit., p. 349n.

<sup>31</sup>Allen, Psychotherapy with Children, p. 89.

not meeting love with love, or hate with hate, or hostility and aggression with similar attitudes, but tolerantly regarding all these as natural human feelings and impulses. This kind of attitude on the part of the therapist provides a stable relationship in which the child may express himself with reasonable freedom (no limitations are placed upon expressions of feeling and impulse even though certain behavior must be checked) and may find some balance between ambivalent impulses and emotions.<sup>32</sup>

### Resistance

Taft amplifies "resistance" in terms of the structure of relationship therapy. According to her, it is at the core of all human relationships and therefore must of necessity be a part of all psychotherapy.

This brings me back to what is after all the only essential in analysis, to speak statically, the bare bones of the process stripped of all content, whether it be drawn from past, present, or future, and this is the meeting of two wills; in this case the actual clash with the child, the living immediately present action and reaction of her will upon mine, which constitutes whatever of reality, therapeutic or otherwise, there may be in the relationship. Nothing is more obvious than the will conflict which Helen sets up from the first moment of her resistance to going with me to the final leaving-taking and her reluctance to say good-by.<sup>33</sup>

With this understanding of resistance, the therapist accepts it as part of the therapeutic experience, and meets it with recognition and clarifications of the child's negative feelings. The aim is not to arouse positive feelings to overcome resistance, but to help the child feel free to

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<sup>32</sup>Phyllis Blanchard, "Case of Tommy Nolan", Psychiatric Interviews with Children (New York: The Commonwealth Fund, 1946) p. 73.

<sup>33</sup>Taft, op. cit., p. 98

express his feelings about coming for therapy.

The therapist has less concern with getting a child to like coming than he has with getting him to express the way he feels. The opportunity to help a child give expression to his more immediate negative feelings would be lost if the therapist tried to cater to his needs and wants. The child must find himself in the situation as it actually is, and he can do so only as he has opportunity to be critical as well as positive in his expression.<sup>34</sup>

### Education

None of the above workers with children attempt to educate or reeducate their patients so that they will be more acceptable to their social group. Rather they maintain that if a child has an opportunity to express himself in a relationship that is accepting and permissive, but also limiting and antagonistic in terms of the understanding will of the therapist, then he will grow in his ability to adapt himself to life.

"All of the clinical problems in child psychiatry involve, in some measure, turmoil that stems from difficulties in defining the interrelated differences in these three roles"<sup>35</sup> that of mother, father, and child. Hence, according to Taft, if the child can undergo any experience which releases him from his negative will to a positive

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<sup>34</sup>Allen, Psychotherapy with Children, p. 98.

<sup>35</sup>Ibid., p. 59.

finding of himself, that experience should register ultimately as a positive gain for society.<sup>36</sup>

### Role of the Child

From the above amplification of concepts and definitions of specific techniques, it is readily apparent that the child directs many aspects of therapy rather than being the passive object of direct treatment. In her synopsis of the case of Helen, Jessie Taft writes:

It is obvious that Helen came with me in the first instance somewhat fearfully and with no desire of her own to see me or any other doctor, but, except for the first bit of pressure which I exerted enough to realize at least one contact, there was no effort to keep her coming. I was ready to let her leave me at any point....

It is evident to me now that the child, like the adult, can save himself, can adapt himself to whatever time is at his disposal, can select and use what he needs, go as deep as it is safe to go under the circumstances and no deeper, provided only the analyst is able to see what the child is doing, to bear it, and to be willing to let the child conquer, to have it, finally, his way.<sup>37</sup>

Thus this group of therapists, who recognize that it is not the child but the parent who takes the first step in beginning therapy, put the responsibility for continuation, use of the limitations and possibilities of the therapeutic situation onto the child. There is a distinct attempt to help the child face his problems, to realize as much as he

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<sup>36</sup>Taft, op. cit., p. 111.

<sup>37</sup>Ibid., p. 34.

is able that he has problems that he can work out during the hours of therapy.

Blanchard believes that the young child has the capability for insight into his problems, according to her analysis of the case of Tommy Nolan.

It seemed that Tommy did schoolwork in his early interviews because he thought that the chief reason for coming to the clinic was his poor work in school. Moreover, as he went on with an effort to master the reading and spelling of words in the next interviews, this was a healthy attack on a real problem; it was not a neurotic tendency to evade coming to grips with it by pretending that no such problem existed or building up some other defense against the unpleasant reality of his failure to do well in school.<sup>38</sup>

Whenever the opportunity arises and Blanchard feels that the child can bear open discussion of the reasons for his parent bringing him to therapy, she sets it in motion.

Allen emphasizes that many children cannot speak about their problems so directly, but he recognizes that they show insight into their difficulties which they express in terms of play.

The play medium so richly used by this boy has its content determined by two factors: the nature of his problem, and his coming to a therapist for help. In the development of his difficulties he was in conflict between the good and the bad.... In taking for himself the role of the rigid moralistic person, who cruelly punished the bad elephant or the bad boy "the worst in the world", he was being the bad person himself in action, but with little responsible ownership of the feeling. When he could reach that point, at a much later period in therapy, the character of his hours

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<sup>38</sup>Phyllis Blanchard, "Case of Tommy Nolan", p. 75.



changed completely. The destructive theme disappeared and Bill's whole interest centered around construction.<sup>39</sup>

Blanchard believes that a child cannot obtain the maximum relief from neurotic fear and anxiety until he can verbalize his feelings. She recognizes a progressive change as the child is able to express himself in activity related to the therapeutic experience rather than in neurotic symptoms; and as he gains more insight and ability to tolerate his aggressive and hostile feelings, he develops a capacity for expressing himself in words.

It will be noted that stress was placed increasingly upon the child's ability to verbalize his feelings. Such ability is perhaps one of the best indications of capacity to tolerate and consciously to experience feelings that have been denied and repressed.... A verbal description also causes the child to retain the feeling within conscious experience for a long period of time, for it takes longer to tell what he feels like doing than actually to do it.<sup>40</sup>

With the development of insight through meeting the limitations and conflicts of the therapeutic situation, the recognition and acceptance of feelings through play and verbalization, and an understanding of his own personal problems, the child comes gradually to show a readiness to assume responsibility for building real-life relationships and tolerance for the affective components.

Throughout this interview, Tommy was confirming the

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<sup>39</sup>Allen, Psychotherapy with Children, p. 148

<sup>40</sup>Blanchard, "Case of Henry Brooks", p. 335.

readiness to end that he had indicated in the preceding interview by being able to decide without hesitancy upon a time for stopping. His thoughts were of the future. He had liked coming to clinic, but he was looking forward eagerly to the flowers that would be blooming and the cherries he would eat after he stopped coming. Even school, which he had disliked when first he came, was now something he preferred not to miss in order to continue at the clinic.<sup>41</sup>

Taft and Allen agree with Blanchard that when the child is willing to accept the responsibilities of growing in a world of limitations and demands as well as satisfactions and gains he will so indicate.

All this was a part of Grace's need to live and to test her newfound strength within the framework of this situation in which she found the first creative use of herself. More and more her interest shifted to home and school affairs, and events outside the room interested her more than things inside. She was indicating in both the verbal and feeling content of her hours, the extent of her progress and her readiness to end.<sup>42</sup>

### Role of the Therapist

In simple but concise terms, Taft describes the functions of the relationship therapist:

I offer a contact in which limitation is accepted and acted upon, at least for myself. If I believe that one hour has value, even if no other follows; if I admit the client's right to go as well as to come, and see his efforts and resistances in both directions even when he cannot; if I maintain at the same time my own rights in time as well as my responsibility and limitations and respect his necessity to work out his own way of meeting a limit even when it involves opposition to mine as it

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<sup>41</sup>Blanchard, "Case of Tommy Nolan", p. 91n.

<sup>42</sup>Allen, Psychotherapy with Children, p. 277.

must, then I have provided the essentials of a therapeutic situation.<sup>43</sup>

From this quotation it is apparent that the therapist must accept activities and words with which the child meets the new experience of therapy, all the while insisting upon the observance of the limits of time, material, and aggressive activity.

The therapist who bears these points in mind will be less concerned about initiating any particular type of play activity. He will be interested in helping the child to do whatever he is ready to do, and will assist and encourage him in choosing what actually is valid and useful for him.<sup>44</sup>

More specific aids in defining the therapeutic situation are offered by Blanchard. In the first interview with Tommy, she found him too timid and fearful to embark upon an activity of his own choosing, so she suggested that he draw when she noted that he looked at the blackboard with more interest than he showed toward other objects.

Probably it is evident that all my activity thus far was directed toward releasing Tommy from his apprehension and helping him to begin some relation with me. I did not try to reassure him or persuade him that he was not afraid but helped him find something he could begin to do. I used this indirect approach, in which I did not mention his fear, because I suspected that to speak of it would only increase it, but that if he could be led into activity and talking to me he would be less fearful.<sup>45</sup>

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<sup>43</sup>Taft, op. cit., p. 18.

<sup>44</sup>Allen, Psychotherapy with Children, p. 126.

<sup>45</sup>Blanchard, "Case of Tommy Nolan", p. 70n.

Another part of the therapist's task is to help the child bear the anxiety and guilt that are occasioned by both behavioristic and verbal expressions of his impulses and feelings. Allen maintains that the therapist should assume a supportive role with regard to such anxiety and guilt feelings, because the child will not be able to bear them when he begins to venture to express them, unless he can project them upon the therapist, and thus make him share the responsibility for them.

Expressing the influence of the analysts more clearly than do Taft and Allen, Blanchard believes that a tentative and flexible diagnosis of the case is necessary for correct recognition and clarification. "The first interviews with a child afford an opportunity to acquire an impression of his personality and to form tentative opinions concerning the nature of his problem."<sup>46</sup> She adds to this information obtained from the social worker; but while regarding all this material as essential for understanding the child and his problems, she feels that the primary orientation of the therapist must be to the child.

This means that psychological theories and the information obtained from outside the interviews must be relegated to the background, and what the patient is presenting in the immediate relationship to the therapist must be kept in the foreground and attention focused on it.<sup>47</sup>

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<sup>46</sup> Ibid., p. 61.

<sup>47</sup> Ibid., p. 64.

Maintaining that the dynamic relationships of life are the core of all therapy, Taft and Allen feel that diagnosis can be confined to an observance of the affects and behavior with which the child enters the therapeutic relationship. If, as quoted above from Taft, the therapist can maintain his individuality and integrity and hold to the limitations of the situation, the child will begin to develop insight into his affective life and into his capacity for bearing the conflicts of reality.

The therapist provides a living symbol of the present world in which the patient is trying to find his place, a world often in strong contrast to that which the patient has built up. In the therapeutic hour the new and the old meet. The patient may have to bring from his past a great deal of factual and emotional content before he can come to grips with the values he possesses in his living. To help the patient grow within the framework of this experience, the therapist must maintain his own realness and not be drawn back into dark recesses of the past to the exclusion of the here and now.<sup>48</sup>

Since the termination of therapy is in the hands of the child with the agreement of the parent, the therapist's only function here is to help the child to come to a decision and to express the ambivalent emotions associated with breaking off any relationship.

#### Role of the Parent

Allen explains the major course of psychotherapy in terms of the interrelated movement and psychic relationship

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<sup>48</sup>Allen, Psychotherapy with Children, p. 123.

of the parent and child as they come for therapy. "The first seeking of help by the parent, and the subsequent coming together of parent and child, with the separation and reunion that takes place, has in it the essence of the entire therapeutic process."<sup>49</sup>

He writes specifically about the importance of the parent in initiating therapy.

The significance of starting treatment is revealed most clearly in some cases by what happens before the child ever reaches the clinic. In those parent-child situations where a deadlock has existed for a considerable period, much is already precipitated by the parents' reaching a decision to do something different about the child's behavior. Making that decision and acting on it immediately introduces a different quality in the relationship between child and parent which in some cases of itself brings about radical changes.<sup>50</sup>

The clinics with which the relationship therapists are associated are set-up so that concurrent treatment is available for the parent, usually the mother, as well as the child.

They arrive at the clinic together for their first appointment but go separately to their interviews with therapist and case worker. At the end of the interview they meet again, and leave the clinic together. The responses that frequently appear during this routine procedure may be dramatized expressions of the problem which has necessitated this step.<sup>51</sup>

Thus in seeking the aid of the clinic the parent admits that she has a problem, and by submitting to the clinic routine

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<sup>49</sup>Ibid., p. 64.

<sup>50</sup>Ibid., p. 108.

<sup>51</sup>Ibid., p. 89.

she acknowledges her readiness to work out the difficulty. During therapy it is hoped that the parent will gain insight into her share of the problem and express emotional readiness to do something about the dysfunction of the relationship between herself and her child.

Both Blanchard and Taft stress the importance of therapeutic work with the parent.

In the case of a very neurotic child I always emphasize that any benefits accruing from therapy are likely to be invalidated unless social work with the parent results in a change in the parent's relationship with the child.<sup>52</sup>

On the whole we have found that children placed in foster homes and in institutions need a longer period of therapy than children who have parents who can share with the child an active part in therapy.<sup>53</sup>

Continuation of appointments and the termination are essentially a privilege of the parent. The therapist can clarify the feelings of the parent who wishes to discontinue before the clinic thinks it is advisable, but they can do no more than that. Of course, if the therapy has shown a good degree of success, then the parent will have obtained enough insight to be willing to let her child cooperate with her in setting the ending date.

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<sup>52</sup>Taft, op. cit., p. 114

<sup>53</sup>Blanchard, "Case of Tommy Nolan", p. 67.

### Summary

The concepts of life and therapy that are characteristic of the relationship school explain living as a process of beginnings and endings, as a dynamic process of development of parts from wholes. Concomitant factors are the conflicting wills of the individuals involved in each relationship and their ambivalent emotions concerning the series of figurative births and deaths. They regard therapy as a unique relationship, having the same characteristics as any life situation, but in which the therapist can be impersonal enough to enable the patient to recognize his ambivalences, his fears, anxieties, his desire to grow, and his unwillingness to leave the past. They emphasize the adherence to limits which define the relationship, so that the child can come to acceptance of himself and life, and still have a desire to enjoy it for what it can be instead of fearing it for what it can do.



## CHAPTER IV

### NON-DIRECTIVE PLAY THERAPY

In the late 1930's another type of psychotherapy began to obtain considerable attention from children's workers. In discussing it, they called it the Rogerian technique because it was developed especially by Carl Rogers. He had recognized that an understanding of the dynamic processes of adjustment had been lost beneath the elaborate diagnostic formulations that were popular in the 1920's. In an attempt to reemphasize the dynamics of adjustment, he discarded most of the Freudian terminology and the doctor-patient relationship. Instead he made use of the face-to-face interviews in which the person seeking help might discuss his problems with freedom according to his need of the moment.

Studying with Rogers at the University of Chicago, Virginia Axline adapted the principles and methods of Rogerian technique or non-directive psychotherapy to her work with children. The results of her experiments were published in 1947 in the form of a book entitled Play Therapy. This book and the writings of Rogers are the sources of the material given in this chapter.

#### Basic Concepts

There is an innate tendency for each child to grow toward maturity in a manner that is most satisfying for his

personality. This implies that he must make adjustments to his environment, of which his peers and elders approve, so that they will offer him affection, approbation and companionship. In order to do this effectively the child must have a chance to live through each period of his growth in a constructive out-going manner. He must be able to live with both his infantile needs and his impulses toward maturity.

The non-directive therapists maintain that they set up a situation in which this type of integrative growth and self-insight can take place. To quote Axline with regard to the concepts basic to this type of psychotherapy:

There seems to be a powerful force within each individual which strives continuously for complete self-realization. This force may be characterized as a drive toward maturity, independence and self-direction. It goes on relentlessly to achieve consummation, but it needs good growing ground to develop a well-balanced structure. The individual needs the permissiveness to be himself, the complete acceptance of himself - by himself, as well as by others - and the right to be an individual entitled to the dignity that is the birthright of every human being in order to achieve a direct satisfaction of this growth impulse. Experiences change the individual's perspective and focus. The impact of the forces of life, the interaction of individual's and the very nature of a human being bring about this constantly changing integration within the individual.<sup>1</sup>

The dynamics of life are such that every experience and attitude and thought of the individual is constantly changing in relation to the interplay of psychological and environmental forces upon him, so that what happened yesterday does not have the same meaning for the individual today as it had when it happened because of the impact of

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<sup>1</sup>Virginia M. Axline, Play Therapy (Boston: Houghton Mifflin Company, 1947) p. 10.

the forces of life and the interaction of individual.... It is the observable flexibility of the personality and behavior of the individual that has opened the door to admit the element of hope and a positive way of looking at the individuals whose seem to have three strikes against them from the beginning. When the individual becomes aware of the part he can play in directing his own life - and when he accepts the responsibility that goes with the freedom of this inner authority - then he is better able to sight his course of action with more accuracy.<sup>2</sup>

Examination of these quotations leads one to believe that this group does not attribute as much therapeutic efficacy to the personal relationship between the child and the therapist as it does to the growth characteristics of a permissive and accepting life situation. They adhere, as do the relationship therapists, to the concept of a creative free will so that they believe that given an opportunity and being free from constant rebuffs by an overpowering environment, the child will be able to make a choice that is most consistent with his personality and the demands of his associates. In fact the child will make a choice no matter how strongly he is rebuffed, but a choice which does not permit complete realization of the self, results in tension, anxiety and fear.

The drive toward self-realization continues, and the individual's behavior demonstrates that he is satisfying this inner drive by outwardly fighting to establish his self-concept in the world of reality, or that he is satisfying it vicariously by confining it to his inner world where he can build it up with less struggle. The

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<sup>2</sup>Ibid., p. 11.

more it is turned inward, the more dangerous it becomes; and the further he departs from the world of reality, the more difficult it is to help him.<sup>3</sup>

### Aim of Therapy

As implied in the material given in the preceding section, the goal of non-directive play therapy is the acceptance by the child of his own dynamic personality and his physical capabilities; in other words, acceptance of himself. Rogers maintains that one of the outstanding characteristics of his technique is that it aims to assist the individual in self-integration rather than in solving one particular problem.

The individual and not the problem is the focus. The aim is not to solve one particular problem, but to assist the individual to grow, so that he can cope with the present problem and with later problems in a better-integrated fashion. If he can gain enough integration to handle one problem in more independent, more responsible, less confused, better-organized ways, then he will also handle new problems in that manner.<sup>4</sup>

All psychotherapy is directed toward the development of a well-adjusted personality. However, Axline devines adjustment in terms peculiar to the thought of this group:

When the individual develops sufficient self-confidence to bring his self-concept out of the shadow land and into the sun and consciously and purposefully to direct his behavior by evaluation, selectivity, and application to

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<sup>3</sup>Ibid., p. 13.

<sup>4</sup>Carl R. Rogers, Counseling and Psychotherapy (Boston: Houghton Mifflin Company, 1942) p. 28.

achieve his ultimate goal in life - complete self-realization - then he seems to be well-adjusted.<sup>5</sup>

### Who Can Be Helped

There is no justification in waiting until a child is seriously maladjusted before attempting to secure some kind of help for him. It seems that there is an element of preventive mental hygiene in a play-therapy experience. Children who do not seem to be seriously disturbed respond quickly to such an experience. And the children enjoy the experience immensely. It is a play experience to them. The fact that it is self-directive removes every vestige of fear of the play-therapy situation, once the child has experienced a contact.<sup>6</sup>

With these words, Axline indicates the non-directive play-therapy situation is a stimulating experience for all children. It does not need to be restricted to those who show behavior problems because, if the method is employed correctly, it cannot do any harm to a well-adjusted child. Since all children must go through experiences of stress, she would advise that a child be permitted to enjoy such an opportunity whenever a parent might fear that the stress was too great for the child. Then deeper difficulties and neurotic tendencies would be avoided.

### Factors for a Favorable Prognosis

Axline indicates that the amount of help that this

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<sup>5</sup> Axline, op. cit., p. 14.

<sup>6</sup>Ibid., p. 62.

type of psychotherapy can offer has a negative relationship with the degree of withdrawal from reality.<sup>7</sup> The greater the break with real relationships, the less hope there is for help through the techniques of non-directive therapy.

Carl Rogers lists eight conditions that should exist for the most favorable prognosis:

1. The individual must be under a degree of tension, arising from incompatible personal desires or from the conflict of social and environmental demands with individual needs. The tension and stress so created are greater than the stress involved in expressing his feelings about problems.

2. The individual has some capacity to cope with life. He possesses adequate ability and stability to exercise some control over the elements of his situation. The circumstances with which he is faced are not so adverse or so unchangeable as to make it impossible for him to control or alter them.

3. There is an opportunity for the individual to express his conflicting tension in planned contacts with the counselor.

4. He is able to express these tensions and conflicts either verbally or through other media. A conscious desire for help is advantageous, but not entirely necessary.

5. He is reasonably free from excessive instabilities, particularly of an organic nature.

6. He possesses adequate intelligence for coping with his life situation, with an intelligence rating of dull-normal or above.

7. He is of suitable age - old enough to deal somewhat independently with life.

8. The parent is relatively treatable, which means that

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<sup>7</sup>Ibid., p. 14.

he has some satisfactions, outside of the parent-child relationship, in social or marital relationships or in personal achievements; he is reasonably stable; he possesses dull-normal intelligence or better; he is young enough to retain some elasticity of adjustment.<sup>8</sup>

Some therapists, notably Axline, do not consider the eighth condition as necessary. She feels that through the process of therapy a child can acquire a feeling of personal worth, a feeling of being capable of self-direction, a growing awareness that he has the ability to stand on his own two feet, an acceptance of himself and an assumption of the responsibility for his conscious personality, which will permit him to synchronize his inward and outward projections of his personality, without treatment of his parent or parental surrogates.<sup>9</sup>

### The Therapeutic Situation

According to Rogers, the therapeutic situation is characterized by a definitely structured, permissive relationship.<sup>10</sup> The word structuring was coined by the non-directive group and means building-up the relationship between therapist and patient in terms of warmth, acceptance, permissiveness, respect and limitations. In treating a child, the relationship exists between an adult and a child

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<sup>8</sup>Rogers, op. cit., pp. 77-78.

<sup>9</sup>Axline, op. cit., p. 15.

<sup>10</sup>Rogers, op. cit., p. 18.

but it is a free, accepting, and permissive relationship in contrast to the doctor-patient or parent-child relationships.

Axline writes that "the relationship that is created between the therapist and the child is the deciding factor in the success or failure of the therapy. It is not an easy relationship to establish."<sup>11</sup> Therefore she lists eight principles that must be followed:

1. The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible.

2. The therapist accepts the child exactly as he is.

3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely.

4. The therapist is alert to recognize the feelings the child is expressing and reflects those feelings back to him in such a manner that he gains insight into his behavior.

5. The therapist maintains a deep respect for the child's ability to solve his own problems if given an opportunity to do so. The responsibility to make choices and to institute change is the child's.

6. The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way; the therapist follows.

7. The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognized as such by the therapist.

8. The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility

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<sup>11</sup>Axline, op. cit., p. 76.



in the relationship.<sup>12</sup>

Thus the basic techniques of non-directive play therapy concern the establishment of a good therapeutic situation. Each one will be expanded below in an endeavor to obtain a better understanding of them.

### Rapport

Rogers describes rapport as a feeling of confidence and trust in the therapist which permits the child to have a sense of security in the therapeutic situation. There is a warmth and responsiveness on the part of the counselor which engenders this feeling of confidence and trust and in some cases it may develop into a "deeper emotional relationship."<sup>13</sup>

However, Axline maintains that the therapist should endeavor to act and speak in such a manner that no deep emotional relationship is developed. She believes that it retards therapy in that it must be broken and worked through before effective treatment can result.

Thus it might be stated that the therapist works to develop a warmth and friendliness between himself and the child rather than a strong emotional expression characteristic of a transference neurosis.

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<sup>12</sup>Ibid., p. 75.

<sup>13</sup>Rogers, op. cit., p. 87.

## Acceptance

Axline believes that acceptance of the child is of primary importance to the success of therapy. She reasons that the child has been brought to the clinic because the parent is seeking to change him, is rejecting some part, if not all of the child.<sup>14</sup>

The therapist must maintain a "calm, steady, friendly relationship with the child...be careful never to show any impatience...and guard against any criticism or reproof - either direct or implied."<sup>15</sup> Otherwise the child will not achieve the courage to express his true feelings and will not be able to avoid guilt feelings.

Rogers likewise believes that acceptance is as important as a warm, friendly relationship in effective therapy; for he defines the counseling relationship as "one in which warmth of acceptance and absence of any coercion or personal pressure on the part of the counselor permits the maximum expression of feelings, attitudes, and problems by the counsellee."<sup>16</sup>

## Expression of Feeling

"There seems to be established value in a full and

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<sup>14</sup>Axline, op. cit., p. 87.

<sup>15</sup>Loc. cit.

<sup>16</sup>Rogers, op. cit., p. 113.

complete expression of feelings to, or in the presence of a calm and sympathetic therapist."<sup>17</sup>

This statement introduced a discussion by Rogers of this important non-directive technique before the American Orthopsychiatric Association. He continued by saying that expression might be verbal or could be made through play materials, drama, writing, or other media. "The feelings expressed may be conscious, or with more complete catharsis, feelings, and attitudes which have been inhibited from recall (unconscious feelings) may be brought out."<sup>18</sup>

The interrelatedness of the principles of permissiveness, acceptance, and expression of feelings is described in this statement by Axline:

The permissiveness that is most conducive to successful therapy is in direct proportion to the acceptance of the child. When he feels so securely accepted by the therapist that he can beat up the mother doll, or bury the baby in the sand, or lie down on the floor and drink from a nursing bottle even though he is nine, ten or eleven years old, and yet can do these things without a feeling of shame or guilt, then the therapist has established a feeling of permissiveness. The child is free to express his feelings. He gives vent to his most aggressive and destructive impulses.... He gets rid of his tensions.<sup>19</sup>

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<sup>17</sup>Carl R. Rogers, "Areas of Agreement in Psychotherapy", The American Journal of Orthopsychiatry, 10:702, October, 1940.

<sup>18</sup>loc. cit.

<sup>19</sup>Axline, op. cit., pp. 97-98.

## Recognition and Reflection of Feeling

Recognition of feeling has therapeutic value. It is sound procedure to help the individual recognize and clarify the emotions he feels - hostile or loving, infantile or mature. This is usually achieved by clarifying verbalization by the therapist of feelings expressed in words or behavior in the relationship.<sup>20</sup>

The non-directive therapists have come to use the term reflection of feeling to denote such verbalization of feelings that the child expresses through words or activity. In many cases the therapist seems to paraphrase the words of the child in order to be careful not to interject any thought or feeling that was not intended by the child. In other words, the non-directive therapist is very careful to avoid anything that might be considered as interpretation.

Axline makes the point that recognition of feeling and interpretation are two different things.

It is difficult to differentiate between them. A cautious use of interpretation would seem the best policy, with the therapist keeping the interpretation, i.e. saying what she thinks the child has expressed in his actions, down to a minimum; and, when using it, basing it upon the obvious play activity of the child. Even then, the therapist's response should include the symbol the child has used.<sup>21</sup>

Rogers especially criticizes the intellectual interpretation used in classical psychoanalysis.

Interpretation of dreams as showing buried hostilities,

<sup>20</sup>Rogers, "Areas of Agreement in Psychotherapy", p. 703.

<sup>21</sup>Axline, op. cit., p. 100.

repressed incestuous or other sexual desires, or a desire for punishment was very common. Often in practice these interpretations were rejected by the client. Interpretation, no matter how accurate, has value only to the extent that it is accepted and assimilated by the client. To trace symptoms back...or to explain the way in which symptoms are easing intolerable life situations, may have no effect, or an adverse effect, on therapy, unless the client can accept these interpretations.<sup>22</sup>

### Resistance

Two of Axline's principles are directed toward the avoidance of resistance. She lists them as six and seven, and with them advises one to let the child lead the way and not to hurry him to effect a quick cure. The therapist does not determine the speed of the therapeutic process, nor does she determine its direction, excepting as her reflecting influences the play of the child.

The therapist keeps her opinions, her feelings, her guidance, out of the therapy hour. The therapist offers no suggestions. The playroom and materials are at the child's disposal, awaiting his decision.<sup>23</sup>

When the child is ready to express his feelings in the presence of the therapist, he will do so. He cannot be hurried into it. An attempt to force him to do so causes him to retreat.<sup>24</sup>

Rogers also stresses the damaging effect of haste when he writes:

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<sup>22</sup>Rogers, Counseling and Psychotherapy, p. 26.

<sup>23</sup>Axline, op. cit., p. 121.

<sup>24</sup>Ibid., p. 127.

Often the client has attitudes which are implied in what he says, or which the counselor through shrewd observation judges him to have.... If they are repressed attitudes, their recognition by the counselor may seem to be very much of a threat to the client, may create resentment and resistance, and in some instances may break off the counseling contacts.<sup>25</sup>

### Role of the Child

The fifth principle indicates that a large part of psychotherapy is in the hands of the child. The non-directive therapists believe that the child achieves a certain amount of insight into his problems through play and the reflection of content and feelings by the therapist. He has the ability to make choices and to institute changes in his behavior.

For the child, aware of his feelings, to make a choice for which he and not the therapist is responsible, is an important step in growth. Such decisions may involve the extent to which he will take responsibility for himself and his problems, on the way in which he will react in other relationships.<sup>26</sup>

The beginning of therapy and the continuation of the early appointments is in the hands of the parent. Usually the behavior problem has assumed such annoying proportions that the parents feel that it is beyond them and that they must seek outside help; or the school authorities recommend to the parents that they do something to help the child. Since play therapy is confined usually to children who are

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<sup>25</sup>Rogers, Counseling and Psychotherapy, p. 152.

<sup>26</sup>Rogers, "Areas of Agreement in Psychotherapy", p. 703.

under eleven years of age, it follows that the child is not old enough to know where he can get help with his problems.

As Axline writes:

The children are not aware that they are problems.... They know only that they are unhappy and defensive and alone against the world.... They are caught in a vicious circle which can be broken only by a realization of their own ability to function as individuals in their own right.<sup>27</sup>

After the first few interviews, the responsibility for continuing is really that of the child. If he does not want to come for therapy, because the tension and stress of his maladjustment are not greater than the stress involved in expressing his feelings about his problems or because he hasn't enough contact with reality to make use of a person-to-person relationship, it is useless to force him to continue because he will not make constructive use of the situation.

As far as termination is concerned, it becomes increasingly evident to the observant therapist that the child is under less strain, that he is less dependent on the therapist, that he has developed an ability to accept himself as he is, and that he is less defensive.<sup>28</sup> The type of play that was used in the core of the therapeutic situation will appear less and less, because the child has solved his problem of adjustment.

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<sup>27</sup>Axline, op. cit., p. 62.

<sup>28</sup>Ibid., p. 51.

Ideally the child's adjustment should be sufficient so that he is now obtaining his satisfactions from his parents, associates, and other individuals in his normal environment, rather than from the therapeutic situation. As this occurs...there is a decreasing need for the therapist's help and a gradual breaking off of the contact, with friendly interest still maintained. In such a situation the termination of treatment is decided as much by the child as by the clinician. It is his lessening need which indicates the conclusion of therapy.<sup>29</sup>

### Role of the Therapist

From the material above it is apparent that the therapist has no responsibility in initiating the first contact. However, once the therapy has started, she alone is responsible for the techniques that are employed and the efficacy with which they are used. She must "structure" the situation so that the child feels her understanding of him and genuine interest in him. He must be made to realize that the therapist is permissive and accepting at all time, that she is sincere and honest, and feels at ease in his presence.

In order to achieve this "the therapist does not patronize the child, hurry him, or, in impatience, quickly do things for him that implies a lack of confidence in his ability to take care of himself."<sup>30</sup> The situation is full of respect for the child's capabilities, not a supportive relationship in which the therapist carries the child along.

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<sup>29</sup>Carl R. Rogers, The Clinical Treatment of the Problem Child (Boston: Houghton Mifflin Company, 1939) p. 351.

<sup>30</sup>Axline, op. cit., p. 64.



Of utmost importance is consistency in technique.

It should be child-centered, following the directions which the child indicates by his play and talk, and adhering to the basic principles laid down by Axline.

Care must be taken to avoid an extreme relationship one way or another. A show of too much affection, too much concern, can easily smother the therapy and create new problems for the child. The crutches of a supportive relationship are just another thing that the child must get rid of before he is 'free'.<sup>31</sup>

The therapist is professional in her dealings with the child, keeps appointments with him as punctually as she would with the adult, does not break appointments unless it is absolutely necessary, does not terminate the contacts without considering the child's feelings and without informing him well in advance so that he will not feel rejected.<sup>32</sup>

One of the most important functions of the therapist is the setting of limits. It is listed as the eighth principle by Axline, and she discusses them as follows:

It is necessary that the therapeutic experience be anchored to reality in some way. What better way can this be done than by the establishment of common-sense limitations? It is important that the limitations once agreed upon should be consistently followed.... It is the element of consistency that provides the child with a feeling of security.<sup>33</sup>

They allow the counselor to be more comfortable and to function more effectively. They provide a framework within which the counselor can be free and natural in dealing with the client. When the relationship is poorly

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<sup>31</sup>Ibid., p. 66.

<sup>32</sup>Loc. cit.

<sup>33</sup>Ibid., p. 134.

defined, there is always the possibility that the counsellee may make too heavy demands on the counselor. The result is that the counselor remains subtly defensive, on guard lest his desire to help should enslave him.<sup>34</sup>

Rogers states that the limits should be set clearly in words with respect to time, affection, and destructiveness. Axline amplifies these statements by writing that the appointment is fixed, and the length of the play contact is determined and held to.<sup>35</sup> If the child feels aggressive and destructive, there are toys upon which he can vent his feelings and which he can destroy. To let him break windows, playroom furniture, or destroy possessions of the therapist does not help him because the situation then goes beyond that of play therapy. Such destructiveness will not be tolerated in situations outside the playroom, so that failure to indicate that it must be confined to toys prevents the child from developing a realization of the limits of his every-day world.

Any attack upon the therapist should be stopped immediately. There can be harm in such a practice...for the therapeutic relationship, to be a success must be built around a genuine respect that both the child and therapist have for one another. A child needs a certain amount of control. He is not entirely self-sufficient.<sup>36</sup>

The limitation of affection may come to a focus in a

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<sup>34</sup>Rogers, Counseling and Psychotherapy, p. 108.

<sup>35</sup>Axline, op. cit., p. 131.

<sup>36</sup>Ibid., p. 133.

request for gifts. It is almost always the rejected child who desires gifts, and the therapist will do well to recognize that no amount of giving can ever satisfy such a child. The constructive possibility is that he may learn that both affection and denial can be a part of one relationship and that the relationship can be a satisfying one, even with its limitations.<sup>37</sup>

### Role of the Parent

Axline and Rogers do not seem to agree concerning the desirability of achieving some insight on the part of the parent in order to treat the child successfully. Both mention that the child is invariably brought for psychotherapy by either the parent or parental surrogate, but word for word agreement stops there. Axline writes:

The parent or parent-substitute often is an aggravating factor in the case of a maladjusted child and while therapy might move ahead faster if the adults were also receiving therapy or counseling, it is not necessary for the adults to be helped in order to insure successful results.<sup>38</sup>

In her book most of the reports are of children who were in situations where there was little insight on the part of the adults toward a better way of helping these problem children.

In very few of the cases did the adults receive treatment of any kind, and yet the children were able to become strong enough within themselves to withstand very trying conditions. It seems as though the insight and self-understanding gained by these children brought about

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<sup>37</sup>Rogers, Counseling and Psychotherapy, p. 106.

<sup>38</sup>Axline, op. cit., p. 68.

more adequate ways of coping with their situations, and since the tensions eased, this in turn brought about a certain change in the adults. This follows through with the explanation of relative, dynamic reactions that are constantly shifting and changing in the light of new experiences. If the child becomes more responsible and more mature, then the adult feels less irritation and less need to nag the child.<sup>39</sup>

In both of his books, Rogers indicates that the parents should have concurrent psychotherapy. He writes in his earlier book:

The child-guidance clinics have led the way in pointing to the need of changing family attitudes and methods of child care, if problem children are to be helped. It is not surprising that studies have shown that for children who are being dealt with in their own homes the most numerous and most important treatment measures are those designed to effect some change in the family atmosphere.<sup>40</sup>

In this same book, Rogers cites several studies to prove that concurrent treatment for parent and child is preferable to just treating the child alone.

In his later book, he writes that one of the conditions of successful non-directive therapy is the relative treatability of the parent. (See page 67 of this thesis.) Evidently there will have to be more research on this point, with some form of quantitative analysis, before it can be decided.

As with the initiation of contact, the continuation

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<sup>39</sup>Loc. cit.

<sup>40</sup>Rogers, Counseling and Psychotherapy, p. 78.

of appointments is basically in the hands of the parent. If he will not bring the child for psychotherapy, permit him to come, pay for it when a fee is required; or if he consistently breaks or is late for appointments, nothing much can be done by either therapist or child. The most that can be done, if the parent is being counseled too, is to call his attention to such resistance.

Both Axline and Rogers state that only that advice is used and acted upon which the client accepts emotionally; so that urging the continuation of appointments when the parent refuses is a waste of time and will probably prevent the parent from even being able to accept psychotherapeutic aid later for either himself or his child.

#### Summary

That there is a strong innate drive within each individual which motivates him toward integrative growth in a permissive and accepting environment is one of the major philosophical concepts held by the non-directive group. In order to aid such growth, they set up a therapeutic situation that is permissive and accepting. After establishing rapport they employ the techniques of reflection to enable the child to gain some understanding of his feelings. They are child-centered, for the child selects the type of play and verbalizes as he wishes. He leads the way and the therapist follows.

## CHAPTER V

### DIRECTIVE AND/OR RELEASE THERAPY

John Levy, professor and later director of the Department of Psychiatry at Columbia University, was one of the leaders of the child guidance movement that began during the 1920's and achieved national recognition by 1930. He used the standard psychiatric approach which was concerned more with the collection of data than with the feelings and emotions of the child. As his experience increased, he emphasized the need for strong rapport and the importance of interpretation in meeting the child's resistance.

David Levy accepted these principles as developed by John Levy and used them in child psychotherapy and in defining the controls of experiments in the release of negative emotions, notably hostility arising from the sibling relationship. In the meantime, Jacob Conn was working at John Hopkins Hospital and Joseph Solomon was close by in the offices of the Mental Hygiene Society of Maryland. Influenced by the experiments of David Levy, they began to set up therapeutic situations in which the problem of the child was reconstructed, and then he was urged to meet the artificial situation with the full force of his destructive emotions. From the work of these four men has developed a method that is known as directive as well as release therapy.

### Basic Concepts

Before the members of the American Orthopsychiatric Association, David Levy called his particular method abreaction therapy. This title was adopted with full cognizance of the classical definition of abreaction and implies that this is a therapeutic method concerned with the release of anxieties and tensions. There is adherence to the concept that excessive anxiety and fear consume and divert psychic energy, with the result that the child is unable to develop normally. Therefore, by setting up an anonymous play situation in which the child can relive the traumatic or aggravating situation, hostile emotions are released and sufficient pressure removed to enable the child to develop normally.

There is full recognition of susceptibility of the child to "desensitization through constant repetition of the same material, i.e. play situations representing the life setting which stimulated his anxieties."<sup>1</sup>

The play interview offers the child an opportunity for an objectivication and immediate reshuffling of perspectives. This usually occurs within one or two interviews during which the child not only learns and accepts what he has contributed to the total situation, but for the

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<sup>1</sup>Joseph G. Solomon, "Active Play Therapy", The American Journal of Orthopsychiatry, 8: 485, July, 1938

first time he finds himself secure in a personal relationship.<sup>2</sup>

### Aim of Therapy

This type of therapy "compels the expression or the recognition of feeling and mobilizes the play activity to release feelings."<sup>3</sup>

Children often speak of personal problems much more freely when engaged in play, while direct questioning is apt to arouse self-consciousness, evasiveness and embarrassment and yield relatively little information. Children are able to reveal attitudes, difficulties and dream contents with greater ease through the medium of dolls.... They can and do speak of intimate personal problems as if they were those of the dolls and seem to enjoy and seize upon this chance.... Gradually they learn to apply to themselves those things they have transmitted to the dolls.<sup>4</sup>

According to the above statement by Conn, he endeavors to work out the fears of his patients through interpretation as well as abreaction. Solomon and especially David Levy set up a doll situation that is directly pertinent to the child's problem. Levy thus lists as the goals of re-therapy, "the simple release of aggressive behavior..., release of hostility aroused by the sibling rivalry relation-

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<sup>2</sup>Jacob J. Conn, "The Treatment of Fearful Children", The American Journal of Orthopsychiatry, 11:751, October, 1941.

<sup>3</sup>David M. Levy, "1937 Symposium", The American Journal of Orthopsychiatry, 7:409, July, 1937.

<sup>4</sup>Jacob J. Conn, "Children's Reactions to the Discovery of Genital Differences", The American Journal of Orthopsychiatry, 10:747, October, 1940.



ship...and lastly the release of specific tensions" arising from the situation of a particular patient.<sup>5</sup> He believes that there is a functional change in the relationship between mother and child when there is a free release of hostile feeling.

### Who Can Be Helped

This type of psychotherapy conforms much more closely to the requirements of applied science than do those discussed in the preceding chapters. Therefore it is to be expected that these therapists describe clearly what types of difficulty can best be treated by their methods. For the best prognosis the neurotic symptoms should have followed a specific event or events. Such symptoms should be of short duration and in the recent historic past of the child. The family relationship should be normal or nearly so. Lastly, the child should be ten years old or younger.<sup>6</sup>

In discussing his work, Conn elaborates concerning the type of overt symptom with which he has been successful.

During the past seven years such problems as ear sickness, fears of kidnapping, hypochondriacal complaints, tics, asthma, sibling relationships, reactions to paren-

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<sup>5</sup>David M. Levy, "Release Therapy", The American Journal of Orthopsychiatry, 9:730, October, 1939.

<sup>6</sup>David M. Levy, "Psychotherapy and Childhood", The American Journal of Orthopsychiatry, 10:907, October, 1940.

tal neglect or oversolicitude and more recently the sex attitudes and sex awareness of two hundred children (ages six, seven, and eight) have been studied by this method.<sup>7</sup>

Solomon has found difficulty in initiating the directive method with children who have been under treatment for some time by other methods. Therefore, he feels that for a good prognosis the directive method should be the first attempt at therapy and not follow a method that has failed.

### The Therapeutic Situation

These therapists employ a group of dolls and pertinent verbal instructions to reenact the traumatic situation. In most cases one doll represents the mother (D. Levy usually uses an amputation doll for this), another the patient; and then dolls are selected and named according to their relationship to the specific incident. In his sibling rivalry experiments David Levy would indicate the mother doll, and appropriate doll for the patient and then a baby doll. He would assist the child in making clay breasts for the mother. Then he would speak as follows.

Now this is the game. The sister comes and sees a new baby at the mother's breast. She sees it for the first time. Now what does she do? Do whatever you think. Go ahead. Don't be afraid.<sup>8</sup>

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<sup>7</sup>Conn, "The Treatment of Fearful Children", p. 749.

<sup>8</sup>David M. Levy, Studies in Sibling Rivalry, Research Monograph No. 2, The American Orthopsychiatric Association, 1937, p. 9.

Then when Levy felt that the child was able to express himself freely, he would use these words to release rivalry: "When the sister saw the baby she thought, 'The nerve, at my mother's breast!'; or 'That's really your baby brother and this doll here is you.'"<sup>9</sup>

Solomon describes setting up an oedipal situation.

I select a doll to represent the patient. Then I suggest to the child that he select dolls to represent the other members of the family. Then I set up a play situation such as putting the mother and father doll together and then ask: "How does the girl feel when the mother and father are together?"<sup>10</sup>

Writing in more theoretical terms, Conn describes the therapeutic situation as follows:

The child doesn't come to be entertained. The play interview is neither a glorified, free-play period or an invitation to release self-assertive hostile tendencies. It is a seriously motivated, purposeful experience in which the child accepts the role of collaborator, an equal, who comes to teach as well as to learn. It fosters a succession of significant decisions which can be carried out in the interval between interviews, rather than a verbal exercise or a preparation for a later doing, which may be carried over into other situations in some mysterious manner.<sup>11</sup>

On the same theoretical level, Solomon writes that the therapeutic situation is an opportunity for the following phenomena to occur:

1. Contact with the child's thinking.

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<sup>9</sup>Loc. cit.

<sup>10</sup>Joseph C. Solomon, "Active Play Therapy", p. 485.

<sup>11</sup>Conn, "The Treatment of Fearful Children", p. 751.

2. Abreaction of the anxiety and aggressive impulses.
3. Working through dependent wishes.
4. Affording alternatives to the feeling of impending tragedy.
5. Release of tender impulses in an atmosphere of acceptance.
6. Alleviation of the sense of guilt.
7. Crystallization of the ego structure in terms of reality.<sup>12</sup>

### Therapeutic Techniques

Proceeding from the general theoretical principles that were indicated by John Levy, the other three therapists have evolved a special, well-controlled method of effecting the seven dynamic activities listed above from the work of Solomon. It is enlightening to consider the categories that have been set up in the preceding chapters as they are regarded by these men and as they facilitate or prevent the attainment of their goals.

### Rapport

In the traditional role of a child psychiatrist, and being somewhat associated with the thinking of the relationship therapists, John Levy emphasized the importance of an affectional tie between therapist and child.

The second way of meeting resistance, and the stronger instrument at the therapist's command is the development of strong affection and respect for the therapist by the

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<sup>12</sup>Joseph C. Solomon, "Play Technique", The American Journal of Orthopsychiatry, 18:402, July, 1948.

patient. During the early phases of treatment, the doctor must keep in mind the patient's need for understanding and acceptance. By giving these the therapist fills a strong need in the individual's life which binds the patient to him, and overcomes the latter's dissatisfaction with his role.<sup>13</sup>

Conn stresses the same point, and uses the same connotation for the term acceptance as do the relationship and non-directive therapists.

From the first he learns from experience that although he has expressed his feelings about his domineering oversolicitous mother, or his envy concerning a more favored sibling that everything he says is accepted in a sympathetic and encouraging manner. In the presence of his mother he only receives praise and commendation for "learning his lessons". In this manner the child is repeatedly put at ease and becomes more and more aware that he has found someone with whom he can converse freely either directly or through the medium of the dolls. Evidence of this relationship is revealed in remarks made by the children to their parents and in scribbled notes found lying about the waiting-room in which the patient writes, "I like you" or "I love my doctor".<sup>14</sup>

In his early experiences with this method (prior to 1938) Solomon held the opinion that there was no need for much rapport between worker and child. In work that he was doing about the same time, David Levy felt that it was only necessary to help the child overcome any initial fearfulness. To do this, he would encourage the child to play with toys and manipulate the amputation doll. Then the controlled situation would be set up and the therapy proceed.

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<sup>13</sup>John Levy, "Relationship Therapy", The American Journal of Orthopsychiatry, 8:66, January, 1938.

<sup>14</sup>Conn, "The Treatment of Fearful Children, ". p. 745.

## Transference

In describing his later work, however, Solomon writes:

The therapist from the first becomes a symbol of relaxation of the superego. If the child is given the privilege of indulging all his fantasies, he becomes more tolerant of his own thoughts. At least he is made to feel that his thoughts as such don't have noxious powers.<sup>15</sup>

The whole treatment situation, including relationship aspects, serves largely for the purpose of exposing the child to a lenient parent image in order to lessen the intensity of the condemning conscience. If self-condemnation reaches a high point, as in a sudden release of hostilities, the therapist can help alleviate some of these feelings through the same medium of play, i.e. pick up a doll that has been knocked down or suggesting the hurt mother be rushed to the hospital to help atone for some aggressive acts.<sup>16</sup>

Thus they explain some of the dynamics of their method in terms of the transference of the role of the superego to the person of the therapist; and the latter's ability to aid and control the release of emotional components is possible because characteristics of the superego and restricting parent have been given to him.

David Levy recognizes also the transference phenomenon during the processes of catharsis and abreaction, and he emphasizes that the child should leave each treatment interview in a state of positive transference. In his description of particular interviews, he calls attention to

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<sup>15</sup>Joseph C. Solomon, "Active Play Therapy: Further Experiences", The American Journal of Orthopsychiatry, 10:764, October, 1940.

<sup>16</sup>Ibid., p. 764.

the number of times that he supports the child in overcoming his fears and expressing his negative feelings, so that the child gives the superego functions over to him.<sup>17</sup>

### Catharsis and Abreaction

As stated at the beginning of this chapter, the classical principles of abreaction and concomitant catharsis form the core of release therapy. Solomon describes the integration of psychic structure that occurs with release:

As the child abreacts his feelings in the relationship situation, he is brought face to face with the products of his own instinctual drives and the actualities of his interpersonal relations. The therapist sets a new level of reality in which appropriate demands are placed on the ego. It must be remembered in this connection that it is not the instincts that are all, but the ego that is called upon to handle them.<sup>18</sup>

As mentioned above, David Levy uses statements to urge or support the child in the expression of negative emotions. "Throughout the experiment, encouraging remarks are made to facilitate the behavior by overcoming anxiety. Every device is used to smooth the path into display of primitive feeling."<sup>19</sup>

There is abundant evidence that the behavior of children is modified by "play therapy", more specifically, that activity with dolls representing mother and baby affect the relationship with the real mother and baby.

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<sup>17</sup>David Levy, "Release Therapy", p. 730.

<sup>18</sup>Solomon, "Play Technique, p. 406.

<sup>19</sup>David Levy, Studies in Sibling Rivalry, p. 22.

A general observation was made that a functional change in this relationship is best achieved when hostility of the primitive degree occurs, generally unhampered by preventing, self-punishing, restoring, and defensive behavior.<sup>20</sup>

He concludes his monograph on Sibling Rivalry with a detailed description of several of the cases and indicates the amount or type of improvement that was noticed in the patient's daily behavior after treatment of this type.

Gonn relies more on the verbal expression of feelings than the actual motor display of them; for guns, knives, soldiers, etc. are not included in the play materials. Under these conditions aggressive manifestations and anxiety situations occur very infrequently.

The play-interview is an opportunity for the child to express himself and, at the same time, reveal to himself the role he has played in his illness. This is accomplished by providing an opportunity for the child to speak for each of a number of dolls, and simultaneously to view objectively all that is going on while he is actively participating in an intimate discussion of his own attitudes. It is not the child but the doll who is afraid of the dark. It is not he who is envious or hates, but the doll-character. Therefore he can give an account of his motives and imaginations which may explain the doll's behavior and consequently his own.<sup>21</sup>

### Interpretation

The directive therapists use two methods to interpret the activities of the play interview so that the child's mo-

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<sup>20</sup>Ibid., p. 65.

<sup>21</sup>Gonn, "The Treatment of Fearful Children", p. 750.



tives, attitudes, and feelings will gradually become clear to him. They speak, sometimes, for one of the dolls (Solomon has a doll which represents the therapist), and they make constant use of direct questions, which help the child to answer in a revealing fashion.

Play, then, serves not only as a means of expression for the child, but also becomes the medium by which the therapist talks to the child. Many of the complexities of human behavior can be discussed through the anonymity of doll play. This can be done even after the child has revealed the problem for which he is coming to the doctor.<sup>22</sup>

When they start a line of questioning they continue as far as the anxiety of the child permits. Conn uses such questions as: "How do you feel? You feel like...? Just like...? What else?"<sup>23</sup> David Levy will ask: "What are you doing? Why scared? What does Mamma do?"<sup>24</sup> He even will give the name of the patient to a doll and that of a sibling to another, so that the situation is clearly indicated as one in which the patient and his relatives are playing the leading roles.

### Resistance

These therapists do not seem to feel that the treat-

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<sup>22</sup>Solomon, "Play Technique", p. 403.

<sup>23</sup>Jacob H. Conn, "Psychiatric Study of Car Sickness in Children", The American Journal of Orthopsychiatry, 8:131 January 1938.

<sup>24</sup>David Levy, Studies in Sibling Rivalry, p. 92.

ment of resistance is one of their major problems. John Levy who made only a small beginning in release therapy, and used a more standard psychiatric approach of direct questioning, seemed to encounter resistance more often than the others. He would meet it by pointing out to the patient many of his attempts to reverse the roles (doctor vs. patient) or even to break away from them.<sup>25</sup> As mentioned under the section entitled Rapport, he felt that the establishment of a close positive rapport due to the patient's recognition of the acceptance and understanding of the therapist was the strongest instrument that the doctor had for meeting or preventing resistance.

David Levy believes that direct questions often engender resistance.

A question may deflect activity, may be regarded by the child as an accusation, may increase the child's opposition, and alter what appeared a natural process of activity in the experiment.... I think, if there can be a rule in the matter, it would be that whenever in doubt about the effect of a question on the flow of activity, it is best to forego it, especially in the early trials.<sup>26</sup>

Solomon feels that he avoids resistance by keeping the situation anonymous. "There are no early attempts to identify the dolls. The situations are kept in the third person so long as the child wishes to remain anonymous."<sup>27</sup>

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<sup>25</sup>John Levy, op. cit., p. 66.

<sup>26</sup>David Levy, Studies in Sibling Rivalry, p. 23.

<sup>27</sup>Solomon, "Active Play Therapy: Further Experiences," p. 763.

Conn makes no mention of this problem at all, as though he hadn't come upon it in his method of treatment.

### Education

In his first article, written in 1938, Solomon states that one of the therapeutic aspects of active play therapy is the incorporation of therapeutic suggestion. He defines this as follows: "At strategic points the therapist incorporates therapeutic suggestions to resolve the child's past problems and to direct future things."<sup>28</sup> He does not explain his statement further, so one would infer that he would interpret so as to give the child insight into his behavior and understanding of the ways in which he can conform to the demands of his family and social group.

In listing the types of cases in which he sets up special groupings of the dolls, David Levy mentions controlled play situations for the purpose of modifying social attitudes. He describes specifically attitudes toward siblings and continues:

This method exploits the child's natural play in which aggression is used against an object without necessarily identifying it. The hostile feelings of the competing older child are gradually released in play to the point of demolishing the doll standing for the rival.<sup>29</sup>

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<sup>28</sup>Solomon, "Active Play Therapy", p. 490.

<sup>29</sup>David Levy, "Psychotherapy and Childhood", p. 907.

He also discusses the release of masculine strivings in girls referred for denial of femininity. Thus he implies that with catharsis the child becomes more amenable to everyday pressures of his social group to make him conform to the accepted mores.

### Role of the Child

As with all forms of child psychotherapy, the decision to seek treatment is the prerogative of the parents. With release therapy, the selection of the equipment to be used during each hour of interview seems to be the prerogative of the therapist. Thus the child finds himself in a situation that has many characteristics similar to situations of his home life and experiences with his medical doctor or his teacher. All these men are doctors so that they are qualified to give a physical examination before psychotherapy begins. Then they proceed to give the child instructions as to his activity during therapy.

What is left for the child is some freedom in the selection of toys, when the child shows resistance or fatigue from the doll set-up. Solomon remarks:

They are allowed to draw, use clay, water, chalk and blackboard etc. If the child has something to say he may use any available means of communication. For that reason there are always available guns, cannons, water pistols and other toys that have a message to convey.... I have learned to encourage spontaneous activity by inviting the child to make up stories of his own with the

dolls. Usually it is the same case of characters he had been using previously and now manipulates to bring out some of his own ideas seeking expression.<sup>30</sup>

In describing his work, Conn, after one or two sessions, asks the child if he wishes to come again to learn his lessons. Then when it seems feasible to terminate he discusses it with his patient.

The termination of the play-interview is accomplished with the consent of the patient who decides whether to return in one, two, or three weeks, in accordance with his individual needs. The interviews are continued until the child himself has no further use for them.<sup>31</sup>

He doesn't permit, however, much if any hostile, aggressive motor activity, for he does not have any guns, cannons etc. among his equipment; so that the child, even here, is restricted according to the dictates of the doctor and must verbalize such aggressive feelings.

Even the amount of anxiety that is released at one particular interview is under the control of the therapist. They urge the child with direct questions as far as they feel it is wise from the point of view of therapy, unless the child absolutely refuses to participate.

Solomon is most lenient in this respect, for he supplies a "doctor doll" on which the child can vent his feelings of anger and hostility for having been trapped in a

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<sup>30</sup>Solomon, "Active Play Therapy: Further Experiences", p. 754.

<sup>31</sup>Conn, "The Treatment of Fearful Children", p. 750.

situation where he has revealed his most important feelings and attitudes. However, if the child has come to the point in his play where Solomon feels that the child is playing out the problem that brought him to therapy, he mentions the problem openly. "To recognize the existence of a problem is good practice, as it gives the child a chance to know the seriousness and the goals of the therapeutic procedures."<sup>32</sup>

### Role of the Therapist

As indicated in the preceding section, the therapist assumes a role similar to that of a doctor, teacher or parent; for he sets up groups of dolls and instructs the child that he and the doctor are going to play a game with them. "After an introductory phase during which the child learned to reply for each of a number of dolls as indicated by the physician, the play was directed by degrees to the study of sex awareness."<sup>33</sup> As this quotation indicates, the therapist is actively in control of the play situation.

David Levy gives the following instructions:

We are to play a game. For the game we need a mother, a baby and an older sister (or brother). Now this is the game. The sister comes and sees a new baby at

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<sup>32</sup>Solomon, "Play Technique", p. 403.

<sup>33</sup>Conn, "Children's reactions to the Discovery of Genital Differences", p. 747.

the mother's breast. She sees it for the first time. Now what does she do? Do whatever you think.<sup>34</sup>

As mentioned under the section on Interpretation, the therapist uses other direct questions to control the flow of activity, release emotions, uncover motives, and generally to lay bare the psychic life of the child.

In order to do this, the therapist must make an accurate diagnosis of the child's problem, which he does in light of the material supplied by the parent, the physical examination, and observations he makes during the first interview or at least the first part of that interview. David Levy lists five categories of diagnosis:

1. Need to modify social attitudes, i.e. sibling rivalry.
2. Need for release of simple aggression.
3. Need for release of infantile pleasure.
4. Need to complete partially fulfilled repetitive act, especially ties.
5. Need for release of masculine strivings in girls.<sup>35</sup>

Solomon writes that the "future of play technique as a medium of therapeutic assistance for the child patient lies partly in the planned handling of each case according to the clinical reaction type".<sup>36</sup> He lists four classifications: aggressive-impulsive, anxiety-phobia, regressive-reaction

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<sup>34</sup>David Levy, "Use of Play Technique as Experimental Procedure," The American Journal of Orthopsychiatry, 3:266, July 1933.

<sup>35</sup>David Levy, "Psychotherapy and Childhood", p. 907.

<sup>36</sup>Solomon, "Play Technique", p. 408.

formation, and schizoid-schizophrenic.<sup>37</sup>

Describing the functions of the therapist in some detail, Solomon writes:

The therapist carries the patient through several treatment sessions in which the child repeats all his hostile demonstrations until he no longer feels the need to do so. When the hostility and guilt have abated considerably, the therapist encourages the child to abandon the dolls and resort to direct conversation concerning the same material as it applies to himself. At strategic point the therapist incorporates therapeutic suggestions to: 1. resolve the child's past problems; 2. direct future things; 3. to prepare him for the termination of treatment.<sup>38</sup>

From this quotation it is apparent how closely the therapist controls the situation. He is accepting and permissive. He is understanding and kind. These qualities help establish rapport and help the child develop a feeling of freedom to express himself. On the other hand, the direction that the play takes, the interviews in which the child will achieve insight, and the beginning of the terminating process, all these are in the hands of the therapist.

Both Solomon and David Levy realize that in urging the child to reveal and release his emotions so rapidly, they arouse hostility toward themselves. Levy describes it as projection of self-punishment, i.e. the child wishes to punish the therapist for permitting or encouraging him to express his hostility toward his parents and siblings.

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<sup>37</sup>Ibid., p. 407.

<sup>38</sup>Solomon, "Active Play Therapy", p. 489.



"Four children of this (sibling rivalry) series attacked the examiner, usually with the accusation, 'You made me do it'."<sup>39</sup> Solomon feels that the child is actually angry with the therapist because he has been tricked into revealing so much; so he supplies a doll to represent the doctor, on which the child can work out his anger. He informs the child: "You can try that on the doll, but if you try that on me I will have to stop you."<sup>40</sup>

John Levy stressed the importance of defining the relationship between doctor and patient in obtaining good therapeutic results.

It is important for the therapist to establish at the outset rather rigid conditions of treatment. The hours, fees and the nature of the doctor-patient relationship must be thoroughly established at the very beginning of contacts. Without this early acceptance of himself as patient and acceptance of the doctor as therapist, treatment is impossible.<sup>41</sup>

All these men employ weekly intervals, although in some cases more frequent interviews can be arranged.

#### Role of the Parent

The parent plays as minor a role as does the child. She confers with either the psychiatrist or a social worker to impart information that will aid in a correct diagnosis.

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<sup>39</sup>David Levy, Studies in Sibling Rivalry, p. 61.

<sup>40</sup>Solomon, "Active Play Therapy: Further Experiences", p. 764.

<sup>41</sup>John Levy, op. cit., p. 66.

It is true that the parent initiates the processes of therapy by seeking aid with her problem. Conn remarks that this is a significant step on the part of a parent and is often associated with an improvement in the home situation.

The acceptance of a child for treatment is in itself a significant therapeutic fact. The much troubled parent finds someone to confide in, who is willing to take over the responsibility for the care of her "fearful" or "nervous" child. This "calling off the dogs" of criticism and nagging is appreciated by both parent and child.<sup>42</sup>

Solomon writes that it is important to "work out the emotional problems of the parents whenever it is possible, especially as it is reflected in the handling of the child."<sup>43</sup> Unless one of these therapists is associated with a child guidance agency that has facilities for helping the parents, however, there are no special arrangements made for concurrent treatment of parent and child. The therapists must depend, though, upon the parent for continuation of appointments; and thus, in a way, the parent's attitude toward termination of treatment is important.

#### Summary

Directive and/or release therapy uses several of the fundamental principles of classical analysis under conditions

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<sup>42</sup>Conn, "The Treatment of Fearful Children", p. 750.

<sup>43</sup>Solomon, "Play Technique", p. 402.

that resemble the scientific laboratory. The therapist in the classical role of doctor directs the patient into activity that will facilitate abreaction and catharsis. With the need to repress affects to ward off fear and anxiety attacks diminished, much of the psychic energy of the child is released for use in growing-up more normally. In his earliest article Solomon listed the advantages of this type of therapy:

1. There are good results in a shorter space of time.
2. Therefore it makes the child guidance clinics available to a larger number of children who need help and also gives help before parents terminate willy-nilly.
3. There is economy of effort because the therapeutic process is utilized exactly where the problems exist.
4. There is no need for much rapport between worker and child.
5. The conflicts are the known quantity and the patient the unknown; whereas in free play the conflicts are unknown and the child, family and therapist are known.
6. Children often respond to active play where they resisted initiating free play.
7. It is especially effective with children from six to ten years old.<sup>44</sup>

Conn, David Levy, and Solomon, who have made exclusive use of this type of psychotherapy, believe that they are successful in a majority of their cases and that follow-ups have indicated that improvements have continued. In the words of Solomon:

As this form of therapy is essentially of the superficial type, the primary object doesn't revolve about

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<sup>44</sup>Solomon, "Active Play Therapy", p. 498.

delving deeply into the unconscious to bring to light material of a pre-genital character. Active play therapy doesn't aim at finding every thought the child has had throughout his life experience, much of which might already have been satisfactorily handled by the child. It is for the army of non-analyzed therapists that this form of therapy has been offered.<sup>45</sup>

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<sup>45</sup>Solomon, "Active Play Therapy: Further Experiences", p. 765.

## CHAPTER VI

### THE COMPARATIVE CHART

In order to analyze the material presented in the four preceding chapters, a comparative chart has been constructed. It is given on the following page. Under each column heading are condensations of the statements made by the authorities for each type of psychotherapy.

Examination of the chart reveals points on which the four groups agree and others on which they disagree. In this chapter, the material under each heading will be discussed in order to accentuate any comparisons that can be made. The following subheadings are arranged so that those concerning which there is the most agreement will be discussed first.

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#### Rapport

All four groups make mention of the therapeutic value of warm, positive rapport. The relationship and non-directive therapists consider it an integral part of their method and a necessity for helping the child to feel free to express himself and gain the feeling that the world is not always hostile and forbidding.

Anna Freud, among the child analysts, works for a close and intimate rapport. She holds as one of the basic tenets

<u>Type</u>	<u>Basic Concepts</u>	<u>Aims of Therapy</u>	<u>Who Can Be Treated</u>
Child Analysis	1-Psychic structure id - ego- superego p. 10  2-Psychosexual development      p. 10	1-Strengthening the ego. i.e. adaptation to reality p. 12 2-Full sexual enlightenment p. 12  3-Lessening the severity of the superego.    p. 12 4-Alleviation of feelings of guilt and states of anxiety. p. 13	Most severe cases of infantile neuroses characterized by fixa- tion,denoted by repetitive and monotonous play and failure to pass on to the next stage of psychosexual development. p. 14
Relationship Therapy	1-Therapeutic role of "waiting to help" p.37. 2-Rankian and Gestaltist concept of development of parts from wholes, i.e.individuation. p.37 3-Rankian theory that life is a series of beginnings and endings. p. 38	1-Insight into Rankian concepts, i.e. that each new experience involves relinquishing part of the past and accepting respon- sibility for the future. p.39 2-Realization that he is a being separate and distinct from thera- pist and thus from mother. p.39 3-Recognition of the limits of life.                      p.39	Must have capacity for estab- lishing contact with therapist. Must have fairly well-defined ego and superego structure. p. 40
Non-directive Play Therapy	1-Basic urge to strive toward self-realiza- tion.    p. 63 2-Life forces of environ- ment and heredity deter- mine and limit the type and extent of self- realization. p.64	1-Self-acceptance,i.e.recognition that one has normally negative as well as positive feelings. p.65 2-Recognition of the freedom and limits of life.    p. 65 3-Acceptance of responsibility of directing his life. p. 65	Must have adequate ability and stability to exercise some con- trol over the elements of his situation. Not for deeply neurotic or psychotic children. p. 66
Directive and/or Release Therapy	1-Excessive anxiety and fear consume and div- ert psychic energy. p. 84 2-Curative effects of catharsis and abreaction. p. 84	1-Release of psychic energy for normal growth by working out fears and anxieties. p.85	Child who developed neurotic symptoms after a specific event.      p. 86

Page references are to material in this thesis.

<u>Factors for Favorable Prognosis</u>	<u>Therapeutic Situation</u>	<u>Rapport</u>	<u>Transference</u>
Endopsychical conflict; when difficulty stems from a harsh environment, limited to extent that environment can be changed. p. 15	Projection of ego and superego functions on analyst, with maintenance of doctor-patient relationship. p. 16 Daily interviews over period of months.	Anna Freud-close and intimate rapport. p. 17 Klein-impersonality of classical analytic situation. p. 17	Development of a transference neurosis is a major technique. This is defined as reviving impulses and affects that had their source in early object relations. p. 18
Neurotic child, i.e. the fearful, self-conscious, cautious child more suited to this type of psychotherapy than primary behavior type.	Real-life relationship between a child and an adult, unique in that the conflicts and ambivalences of life are pointed up. p. 41 Limits of time and aggression are stressed. p. 42 Relationship is that of understanding and permissive adult rather than doctor and patient. p. 42	Positive relationship necessary so that child will feel free to express himself. p. 44	Strong positive rapport rather than transference. Support for expression of negative emotions to facilitate expression of positive feelings. p. 45
The smaller the break with reality, the better the prognosis. The more amenable the parent to helping himself and his child to gain insight, the better the prognosis. p. 67	Definitely structured, permissive relationship which aids the child in developing insight and stimulate integrative growth. p. 69	Warm, friendly relationship necessary to develop a feeling of security in the therapeutic relationship. p. 70	No recognition of the technique of transference. Stree warm, friendly acceptance to aid maximum of expression of feelings, attitude and problems. p. 71
Symptoms should be of short duration and in recent historic past of child. Family relationships be nearly normal. Child be ten years old or younger. p. 86	Specific doll set-up to abreact specific traumatic event. p. 87	Only enough rapport to overcome initial fearfulness. p. 89	Transference upon therapist of parental image and superego functions. p. 91

### Catharsis

Defined as the release of distorted or displaced emotions. Effected by correct interpretations that facilitate insight. Authorities are divided as to whether it should proceed slowly or rapidly.

p. 21

### Interpretation

Integral part of analysis and used in conjunction with free association. Use the language of the id as defined by the dream-interpretations of Sigmund Freud. Authorities are divided as to whether it should proceed slowly or rapidly.

pp. 22-24

### Resistance

Defined as the overt manifestation of the ego's defensive operations against repressed instinct entering consciousness. Prevent or break it down by persuasion or interpretation.

p. 26

### Education

Anna Freud analyzes and also instructs the child in the demands of his social group. Melanie Klein believes that if the psychic structure is integrated the child becomes amenable to instruction from his elder.

p.27

Expression of positive and negative feelings toward present situation rather than true catharsis. Emphasize recognition of ambivalent feelings.

p. 46

Clarification of content and feeling rather than classical interpretation. Give child insight as to how he is using his past experience in the present situation

p. 48

Part of the ambivalence of human nature. Meet it with recognition and clarification of child's negative feelings.

p. 50

No attempt to instruct the child in the demands of his social group. Feel that if child learns to accept the limits of a real-life relationship he will be more amenable to instruction from his elders.

p. 51

Expression of positive and negative feelings toward elders and contemporaries. Recognize the possibility of catharsis but do not work for it.

p. 72

Recognition and reflection of feelings rather than interpretation. Reflection is a technique peculiar to this group, and is defined as paraphrasing the expressions of the child so that he can recognize his feelings.

p. 73

Therapist can reflect child's resistive efforts. However she respects child's ability to solve his problems and institute change, so never uses persuasion.

p. 74

No attempt to educate child. Only attempt to anchor therapeutic relationship to reality is the maintenance of the limits of time and inviolability of the person of the therapist.

p. 78

Catharsis of the repressed affective components and concomitant abreaction of traumatic events necessary for integration of the psychic structure.

p. 92

Use direct questions to urge the child to reveal his affects. Also speak as one of the dolls to enlighten the child.

p. 94

Do not consider the problem of resistance because the technique of abreaction and catharsis is so stimulating. Also avoid over-anxiousness which would arouse resistance.

p. 95

Suggest to the child resolutions concerning future activity. Also believe release of psychic energy through catharsis gives more energy for socially accepted actions.

p. 96



Role of Child

- 1-Does not initiate analysis.
- 2-Needs will and decision to be cured or realization of relief being obtained.
- 3-Some control as to course of his play.
- 4-Not much influence in determining the time of termination.

p. 29

Role of Therapist

- 1-Develop rapport, a transference neurosis facilitate catharsis and meet resistance.
- 2-Interpretation of ego defenses and id-impulses, to produce insight.
- 3-Determination of time and place for analysis.
- 4-Determination of date of termination.

pp.30-32.

Role of Parent

- 1-Decision to begin therapy.
- 2-Must have a modicum of insight into child's problem for good prognosis.
- 3-Must be a relation of confidence between parents and analyst.
- 4-Through fee, has some influence on termination.

p. 33

- 1-Does not initiate therapy.
- 2-Responsibility for continuation and use of the limitations and possibilities of the therapeutic relationship.
- 3-Shows some insight into his problems.
- 4-Some ability to verbalize his problems.
- 5-Readiness to assume responsibility for life relationships.

pp. 52-54

- 1-Acceptance of activities and words which child uses.
- 2-Admit child's right to continue or terminate as he wishes.
- 3-Insistence upon observance of limits of time, material and aggression.
- 4-Support child in expressing anxiety and guilt feelings.
- 5-Tentative and flexible diagnosis.

pp.55-58

- 1-Decision to begin therapy.
- 2-Willingness to separate from child for interviews and readiness to work out problems
- 3-Some insight into the problem as it affects both her and child.
- 4-Continuation of appointments and termination.

pp.58-60

- 1-Rarely initiates therapy.
- 2-Some insight through play and reflection of content and feeling.
- 3-Makes choices that lead toward integrative growth.
- 4-Responsibility for continuation and termination.

pp. 75-77

- 1-Proper use of the techniques of clarification and reflection.
- 2-Effective structuring.
- 3-Be permissive, accepting, sincere and honest.
- 4-Develop good rapport.
- 5-Permit the child to lead the way in play, conversation, continuation, and termination.

pp. 77-79

Axline believes that the role of the parent is insignificant. Rogers believes: the parent should be relatively treatable, i.e. have satisfactions in social and marital relationships; be reasonably stable; and be intelligent and young enough to adjust. Continuation and termination of appointments. pp80-82

- 1-Does not initiate therapy.
- 2-Plays inferior role similar to doctor-patient or teacher-child relationship.
- 3-Some freedom in the selection of toys.

pp.97-98

- 1-In role of doctor, diagnoses case.
- 2-Sets up play situation and instructs child in responses.
- 3-Uses direct questions and interpretation to effect catharsis.
- 4-Gives suggestions for good resolutions and suggests or aids child in decision to terminate.
- 5-Insists on limits of aggression toward therapist.

pp. 99-102.

- 1-Supplies information for diagnosis
- 2-Seeks aid and help for child.
- 3-Through fee, has some influence on continuation and termination.

p. 103

for all education and psychotherapy with children, that the child works only for those he loves. Melanie Klein adheres to the classical approach of psychoanalysis and believes that only enough rapport is necessary to aid the child in overcoming any initial fearfulness. This same viewpoint is held by the directive therapists.

### Catharsis

Classical analysts define catharsis as the release of distorted or displaced emotions. The child analysts and release therapists maintain that a child consumes so much energy in repressing and controlling these affects, that too little is left for normal growth. Therefore they consider it one of the major techniques of child psychotherapy and employ it in conjunction with abreaction.

The relationship and non-directive therapists recognize the possibility of catharsis during the therapeutic hour, but they do not work for it. Since they hold that the therapist is working with the child as he is now, and not as he was in the past, they prefer to discard the term catharsis and use the phrase "expression of positive and negative feelings". They encourage the child to express all feelings toward the therapist, the therapeutic situation and his present home and social environment. The relationship group emphasizes especially the ambivalence of all emotions

to help the child realize that it is normal to love and hate the same person at the same time.

### Interpretation

The technique of interpretation, like that of catharsis, was developed by the early analysts. It is an integral part of child analysis, and means that the therapist translates activities and words of the child in terms of the dynamics of psychic structure and psychosexual development. In interpreting they use the language of the id, as defined by the work of Sigmund Freud. As a technique it is used to facilitate catharsis and enable the child to gain understanding of himself and insight into his problems.

There is a distinct break between the group headed by Anna Freud and those who follow Melanie Klein as to the method of interpreting. The former believe that interpretations should proceed slowly, beginning with the ego defenses and then with deeper psychic structure as it appears. The latter believe in delving into the id and early object relations immediately because they can thereby remove resistance.

The release therapists interpret the activities and words of the child in terms of the specific event that is being reenacted in psychotherapy. They use direct questions to urge the child to accept these interpretations and thus

gain an understanding of his affects and ego defenses.

The relationship and non-directive therapists avoid the use of the word interpretation. Instead they employ such terms as clarification of feeling and content, and recognition and reflection of feeling and content. Reflection is a term coined by the non-directive group and seems to be a paraphrasing of expressions, or verbalization of activities of the child during the therapeutic hour. The relationship therapists also verbalize what they believe the child is doing or saying; but they are not as careful in paraphrasing almost word for word as do the non-directive therapists. Both groups believe that together with free expression of emotions, understanding of affects and their ambivalences is the most important tool of psychotherapy.

### Resistance

Defined as the overt manifestation of the ego's defensive operations against repressed material entering consciousness, resistance is openly attacked by the child analysts. Anna Freud advocates the development of a strong affectionate tie between analyst and child which results in relinquishing the ego and superego functions to the analyst. In that event, the child follows all advice of the analyst and thus does not permit too much resistance. Melanie Klein breaks it down by deep interpretation; for she be-

believes that if a child understands the repressed material, he will not have any reason for avoiding it.

It is considered a part of all human emotional structure by the relationship and non-directive therapists to resist change and hold to the security of the past. They meet such resistance with clarification and reflection so that the child may have some understanding of this ego defense.

By avoiding over-anxiousness and setting up the therapeutic situation so that there is maintenance of the roles of doctor and patient, the directive therapists encounter little resistance.

### Transference

The development of a transference neurosis is a major technique of the child analysts. By effecting this, they revive impulses and affects that had their source in the early object relations formed by the child. Thus they are able to learn why the child built up neurotic ego defenses and help him to understand them.

The directive therapists need some transference upon them of the parental image and superego functions in order to urge the child to express his emotions during the doll-plays. This comes naturally to children, due to their dependent position in life.

The other two groups stress strong positive rapport of warm, friendly acceptance rather than transference. They believe that such a relationship encourages the expressions of present emotions as developed from past experiences. What they are working with are present feelings and situations, so that they do not want to deal with material that should be relinquished to the past.

### Education

Anna Freud has written much concerning the responsibility of the analyst in educating the child in the demands of society. She maintains that it is neglectful for one to release the id-impulses and then not control them with proper instruction. The directive therapists also believe that they should aid the child in forming resolutions for acceptable future activity.

All psychotherapists believe that the child grows more educable as he responds to the healing aspects of therapy, but the other two groups leave education to the teachers.

### Role of the Therapist

Drawing conclusions from the paragraphs above, it would seem that a therapist should develop rapport, and employ some technique to facilitate the expression of feelings.

Some therapists make use of interpretation and others clarify or reflect. There should be some recognition of the ego defense of resistance and a decision as to the method of meeting it. Thus all four groups believe that the therapist must be constantly alert and facile in his expressions. He directs or "structures" therapy so that there is a feeling of permissiveness, acceptance, sincerity and honesty. He has to be ready to reflect, clarify or interpret with such skill that he truly helps the child to see and understand himself as he is.

Another function of the therapist is that of setting limits. The relationship group insist upon the observance of limits of time, material and aggression. The non-directive therapists observe similar limits to anchor the therapeutic situation to reality. Of necessity the other two groups set time limits for their appointments so that they can maintain their schedules; and the directive group limits the expression of aggression to the dolls.

The child analyst must be prepared to diagnose the difficulty, and after obtaining information from the play and verbalizations of the child be skillful in aiding in the rebuilding of the child's psyche. When she feels that this has been accomplished, she determines the date of termination.

The directive therapist must also be prepared to make

a correct diagnosis of the problem. He must obtain information from the parent and child that will be used in setting the stage for abreaction of specific incidents and catharsis of specific affects. When this has been accomplished he discharges the case.

For the relationship or non-directive therapist it is essential that she impart the feeling that she is at the service of the child and believes that he has within him the ability to effect changes toward integrative growth. Thus she leaves to him the determination of the specific incidents that are brought to therapy and the decision to terminate.

#### Role of the Child

In line with his dependent role in the family, the child seldom has an opportunity to initiate any type of therapy. The analysts and release therapists continue this role of dependency during therapy by investing themselves with the attributes of a parental surrogate and doctor. The release therapists do not permit much freedom in play. Instead the child plays with the dolls as directed by the therapist. Only his verbalizations and recognition of the accuracy of interpretations are left to the child.

The analysts offer a selection of toys to the child. By their interpretations and development of a transference neurosis, the direction which the play takes is determined.



more by the analysts than by the child. However, these therapists believe that when the child realizes that he is obtaining relief from his problems, he becomes eager to cooperate in therapy. His willingness to be cured is essential for progress.

The relationship therapists permit the child considerable freedom in the selection of toys. They believe that it is his responsibility to continue therapy and to make use of the limitations and possibilities of the therapeutic relationship. If psychotherapy is to have real significance for the child, he will develop some recognition of the necessity of leaving behind infantile things in order to grow into the future. Then he will be ready to assume responsibility for building real-life relationships.

The non-directive group believes that freedom to use material in any manner in which they wish and freedom to express all affects are the most important aspects of therapy. With the direction of the therapeutic hour in his hands, the child is free to make choices that lead toward integrative growth. His is the responsibility for continuing appointments and deciding to terminate.

#### Role of the Parent

It is necessary for the parent to take the first

steps toward psychotherapy, and her goodwill toward treatment is needed so that the child will be brought for each therapeutic hour. She plays a controlling and cooperating role in all therapy through the payment of the fee. She can terminate at any time by refusing to pay it.

Anna Freud and the relationship therapists feel that the parent needs help in realigning his emotional structure or patterns so that the child and family can gain the most from therapy. They believe that the parent must have some insight into the problem if the child is to improve; for most children's difficulties stem from maladjustments in parent-child relationships.

The non-directive group is split on this point. Carl Rogers maintains that the parent must be relatively treatable in terms of age, intelligence, psychic structure and social adjustments in order to do much with the child. Axline, however, adhering to her belief that there is a strong force for integrative growth within all children, writes that the child can gain much without the cooperation of the parent.

#### The Therapeutic Situation

A relationship between an adult and a child is the outstanding characteristic of a therapeutic situation. In the analytic and release types of psychotherapy, there is the development of a doctor-patient or teacher-child relationship.

The relationship and non-directive groups avoid the parent-child relationship and all the feelings that go with it. They work to develop a situation in which the child feels free, somewhat independent and able to make his own decisions.

Using the authority of a parental surrogate, the analyst works to enable the child to relinquish his ego and superego functions for a time, so that he comes to depend upon the directions and advice of the therapist in many of his activities. Gradually, through the acceptance of the interpretations of the analyst, the child develops understanding of the id-impulses and then rebuilds his ego and superego more in line with the demands of reality.

Relationship therapy is somewhat supportive during the treatment interviews, for these therapists encourage the child to project some of his hostile impulses on them. They endeavor to initiate a real-life relationship that is characterized by a beginning and ending, and all the ambivalent emotions that accompany a figurative birth and death. In addition they stress the limits of time and aggression, for they maintain that learning to accept the limits of therapy carries over to an acceptance of the limitations of life. Likewise the ability to enjoy the possibilities of the therapeutic situation carries over to an ability to enjoy the possibilities of life.

The non-directive therapeutic situation is characterized by the warmth, acceptance and permissiveness of the therapist. The therapist uses words and actions to convey these attitudes to the child and also to set the few necessary limits of time and aggression against the therapist and equipment. Otherwise there is no plan of integration of the psyche or insight into the dynamics of life on the part of the child, beyond what is stimulated by his previous experiences.

The directive therapists set up a situation that resembles a controlled experiment in many respects. They have definite aims they want to attain and specific methods for effecting them.

#### Who Can Be Treated

The child must have sufficient awareness of reality to be able to establish a relationship with an adult in order to be treated by any method of psychotherapy. Both the relationship and non-directive therapists attempt to limit their cases to children who have fairly well-defined ego and superego structure. Such problems are often described as the more or less temporary neurotic states that are characteristic of childhood. Many times the child will outgrow such conditions provided that the environment does not degenerate; but psychotherapy helps him to discard his neuro-

tic symptoms more quickly and to direct his future life in a more healthy fashion.

The relationship therapists in particular, and some of the non-directive therapists insist on concurrent psychotherapy for the parent to prevent the environment from degenerating. Thus they work to improve the environment, so that they can take a neurotic in embryo, help him to discard his ego defenses and return him to a more understanding environment.

The directive therapists have set up a good diagnostic structure by which they limit their cases to children whose neurotic symptoms are so recent that they have not become an inherent part of the psychic structure. Thus they have been able to treat successfully hypochondriacal complaints, tics, asthma, etc., all of this symptoms seem to imply difficulties severe enough for the child analysts. In addition they attempt to limit their cases to families that are more or less normal and treat children that are ten years of age or younger.

When symptoms are indicative of difficulties that are deeply imbedded in the psychic structure, the only type of therapy that offers hope seems to be that of child analysis. The analysts feel that they are equipped to effect favorable changes in children who have refused to continue to develop and become fixated at one of the infantile levels.

### Factors for a Favorable Prognosis

In line with the type of case that they select, the analysts believe that their work is more successful when the conflicts are endopsychical and not amintained by a harsh or neurotic environment. When the environemtn is abnormal, the amount of progress the child will show will be limited by the extent to which change can be made in his homelife.

As stated in the section above, the release therapist selects his cases according to criteria that have been determined from the treatment of many children. If the child's problem presents a syndrome that meets these criteria then chances for progres are good.

The other two groups seem to have more success the smaller the child's break with reality. The fearful, self-conscious, cautious child is more suited to these types of psychotherapy than the child who shows a lack of superego structure. In addition, the more amenable the parent to helping himself and his child, the better the prognosis.

### Aims of Therapy

All psychotherapy has a general common aim, namely to aid in the development of an emotionally secure child who can make normal adjustments towards the demands of life. Each group, however, differentiates itself from the others by selecting an approach to this goal in line with their

basic concepts of life and psychic integration.

In line with their concepts concerning psychic structure, the child analysts endeavor to strengthen the psyche of the child by giving him assistance in gaining insight into his id-impulses, his ego defenses and the excessive severity of his superego. In effecting this, they are able to alleviate feelings of guilt and anxiety states, because the child develops some understanding of the bases of these feelings.

With similar concepts, but limited by the brevity of the period of treatment, the release therapists work toward quick relief from fears and anxieties by using the techniques of abreaction and catharsis. They feel that such relief has an integrative effect on the psyche of the child because energy that has been employed in allaying fears and anxieties and in maintaining ego defenses can be transferred to activities concerned with more normal development.

Holding that a realization of the truth of the Rankian philosophy of life is most important, the relationship therapists endeavor to develop tolerance if not understanding for the constant relinquishments and acceptances of life. They hope to help the child to accept emotionally the need to grow away from the infantile state of dependence toward an individuality that assumes the responsibilities of life. If they can effect insight on the part of the child, they hope to

develop a willingness to give up whatever of the past is necessary in order to be reborn to the beauties and possibilities of the future.

The non-directive therapists try to develop understanding and tolerance of the self by helping the child to demonstrate to himself that his negative feelings are as acceptable and normal as his positive ones. They hope that when the child comes to this state of self-acceptance, he will cease to use an excessive amount of energy in fighting his aggressive and hostile impulses. Thus he will have more psychic energy to employ in directing his life along socially accepted channels. In other words, they believe that the drive toward integrative growth is so great that given a small chance for self-understanding and acceptance, the child will welcome the challenges and possibilities of life and move on normally.

### Basic Concepts

As implied in the above section, each group of psychotherapists has a distinctive outlook on life and psychic structure. The child analysts and release therapists are somewhat agreed concerning the development of the psyche and the dynamics of psychic energy. They differ in that the analysts maintain that an intensive rebuilding of the psyche is necessary for effective treatment, while the directive



group believes that catharsis and abreaction of the traumatic experiences are sufficient to initiate integration.

The relationship therapists discard Freudian theory and adhere to the principles expounded by Otto Rank. They believe that life is a series of beginnings and endings and that individuals, with their natural ambivalence, are hesitant to leave the past but at the same time eager to meet the future. Thus if they can offer help to an individual so that he can understand his ambivalences and the constant change of life, they are effecting psychotherapy.

The non-directive therapists do not adhere to any elaborate structure of life or of the psyche. They do believe that the life forces of environment and heredity determine and limit the type and extent of self-realization. Each individual possesses a basic urge to strive toward this self-realization, and they offer a unique experience which aids the child in growing and maturing.

### Summary

In this chapter, statements by the authorities of each type of psychotherapy have been presented in the form of a chart. Then these statements were compared to accentuate points of agreement and disagreement. It was possible to select a few points of agreement and several on which they disagreed.

## CHAPTER VII

### CONCLUSIONS, SUMMARY AND RECOMMENDATIONS

#### Conclusions

It is possible to draw more concise conclusions from the material in the preceding chapter than was done there. These are the points on which the different groups of psychotherapists show the most agreement.

All agree that the therapeutic situation is characterized by a relationship between a child and an adult and that some amount of rapport is necessary to establish the relationship.

All groups recognize the probability of resistance to psychotherapy on the part of the child and suggest methods for overcoming it.

The child analysts and release therapists concur on the importance of catharsis, interpretation and transference. The relationship and non-directive therapists prefer to discard these classical techniques and encourage the child to express his negative and positive feelings toward the therapists, the therapeutic situation and his home and social environment. They facilitate this by clarifying, recognizing and reflecting feeling and content, and through the demonstration of their warm friendly acceptance of the child.

That the therapist has some responsibility in training the child according to the demands of society is believed by some child analysts and some release therapists. The other two groups maintain that such work is the function of a teacher rather than a therapist.

Each of the four groups lists among the functions of the therapist those of establishing rapport and of employing some techniques to facilitate the expression of feelings and to meet resistance. They also believe that the therapists must "structure" the therapeutic situation so that there is the feeling of permissiveness, acceptance, sincerity and honesty.

The therapist must set limits of time and aggression that are necessary to anchor the therapeutic situation to reality and permit the therapist to function most adequately.

The child analysts and directive therapists are prepared to diagnose the difficulty and plan the psychotherapy accordingly. When the child has shown sufficient progress then the therapist discharges the case. The other two groups believe that the therapist is at the service of the child and make him responsible for continuing and terminating therapy.

The child seldom initiates psychotherapy of any kind due to his dependent role in life. The child analysts and directive therapists continue this dependency relationship during the therapeutic session. The analysts permit the child

some freedom in the selection of toys and in verbalizing, but the directive therapists indicate even the toys that are to be used.

The relationship and non-directive therapists allow the child as much freedom as is possible within the defined limitations in the selection of toys and in play activity. They believe that such freedom associated with the responsibility of continuing and terminating psychotherapy leads to integrative growth.

All four groups recognize that the parent is the one who usually initiates psychotherapy and that through refusal to permit the child to continue, can terminate therapy. The relationship therapists, part of the non-directive group, and Anna Freud's followers believe that the parent should receive concurrent treatment, or have received it recently enough, so that she can achieve some insight into the problem of the child.

All four groups agree that a relationship between an adult and a child is the outstanding characteristic of a therapeutic situation. In the analytic and release types of psychotherapy there is the development of a doctor-patient or teacher-child relationship. The relationship or non-directive therapist works to develop a warm friendly relationship between himself and the child so that the child feels free to express himself and assume responsibility for himself.

In order to utilize the possibilities of psychotherapy the child must have sufficient awareness of reality to be able to establish a relationship with an adult. The relationship and non-directive therapists offer the best prognosis when the child has a fairly well-defined ego and superego structure. The directive therapists limit their cases to children whose neurotic symptoms are so recent that they have not become an inherent part of the psychic structure. The child analysts are equipped to treat children who have become fixated at one of the infantile levels. They offer the best prognosis when the conflicts are endopsychical.

To aid in the development of an emotionally secure child who can make normal adjustments towards the demands of life is the general common aim of all psychotherapy. The child analysts effect this by assisting the child in gaining insight into his id-impulses, his ego defenses and the excessive severity of his superego. The directive therapists work for the release of psychic energy for integrative growth by employing the techniques of abreaction and catharsis to give quick relief from fears and anxieties. The relationship therapists endeavor to develop tolerance for the constant relinquishments and acceptances of life so that the child will be eager to accept the conditions of life and meet its challenges. The non-directive therapists try to help the child achieve self-understanding and acceptance of all his

negative as well as positive feelings so that he will cease to use an excessive amount of energy in fighting his aggressive and hostile impulses.

The Freudian theories of psychosexual development and psychic structure are the major concepts adhered to by the child analysts. The release therapists also accept these concepts but emphasize the importance of catharsis and abreaction for releasing psychic energy for normal growth. The Rankian principles that explain life as a series of beginnings and endings and the concepts of individuation and ambivalence form the core of the theoretical structure of relationship psychotherapy. The non-directive group believes that each individual possesses a basic urge to strive toward self-realization and will do it if life forces are at all favorable.

### Summary

Four chapters of this thesis contain material from the writings of outstanding workers with each type of psychotherapy - child analysis, relationship therapy, non-directive therapy, and directive and/or release therapy. Their statements concerning their basic concepts, the aims of psychotherapy, the types of maladjustments they can treat and the factors determining a favorable prognosis have been quoted. In addition their definitions of a therapeutic situation and the therapeutic techniques of rapport, transference, catharsis,

and interpretation have been presented. Their thoughts concerning the problems of resistance and education as well as their description of the functions of the therapist and the roles of the child and parent are also given.

All this material was condensed for presentation in the form of an analytical chart to be found on page 107 of this thesis so that the reader can determine on which of the above points there is agreement or disagreement. The writer attempted to highlight the comparisons in chapter six and list them in this chapter. Through the comparative chart and reference to the source material which explains it, the student of psychotherapy with children will be able to acquire some background with which to approach his study.

#### Recommendations for Further Research

In reading the material listed in the bibliography and in writing this thesis, the writer realized how much research is needed in the field of psychotherapy with children. Many therapists who do not adhere to one particular school of thought select techniques that are most suited to their personality and the type of case they treat, but this can be done only by the slow process of personal experience. It would be most helpful if some quantitative measure of successful psychotherapy could be developed. If this were available then it might be possible to evaluate each of the techniques of

rapport, transference, catharsis and interpretation in terms of what they contribute toward successful treatment. Something might be achieved toward deciding the necessity for concurrent treatment of parent and child and the functions of the therapist and child during the therapeutic hour.

This thesis attempts to report and compare <sup>some of</sup> what has been written on these points, accentuating points of agreement and disagreement.



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