Summer Seminar in Child Therapy - Association of Child and Adolescent Psychotherapists

July 20, 2018

Jim Grabowski, MA, LCPC
Faculty, CAPT at Chicago Psychoanalytic Institute, and
Faculty, ICSW
2132 W Roscoe, 2nd Floor
Chicago, IL 60618

Today we will look at one way to think and work psychoanalytically in our clinical work with children. We will not look at THE way, or ALL the ways. Every therapist finds their own way among the various ideas, myths, stories in the literature. We also draw from who we are, how we are wired, what our experiences have been, clinically and otherwise. Choosing your theory doesn't involve selecting a political party, a club, or a product for sale. It means articulating "the way I work." The way you work will always be incomplete, and developing over time. It will have gaps, just like the unconscious, and just like our state of understanding humanity and development. The psychoanalytic child therapist tolerates not knowing, tolerates incompleteness, because complete development means development is over, which means omnipotence, which doesn't exist, or it means death. Life is incomplete, and so should be every theory or work plan.

Our plan for today is to review a way of working, and as much as can be said about it in the time we've set aside. We will start with basic assumptions about health development, then move on to how we assess problems, and then how to decide what to do about these problems people are coming to us for help with.

I. Understanding Normality

Our assessment of pathology necessarily proceeds from what we understand

to be healthy normal development. A developmental approach, which we will use today, sees therapy as helping to restore one onto a path of healthy growth.

Our understanding of healthy growth comes from several sources. One is when we meet with ill patients, and we try to understand them and where something went wrong. This presumes that the past affects the present, and that the source of problems have a history. This method may be criticized as *pathomorphic* [shaped by illness] and retrospective. Those criticisms are valid, and yet, the method has contributed much to our understanding. In part, by finding the areas where development goes wrong, we are able to define what the areas of development are, and then proceed to thinking about what healthy growth in these areas would look like. This method generates important questions, although the answers are found outside the consulting room through child observation and study. So this method is helpful but not at all sufficient.

A. Clarity on Ego and Drive development

For us to make use of earlier knowledge, we need to be able to understand the dialect it is written in. The writings on ego an id development were written in the dialect of classical Freudian psychoanalysis. The difficulty in reading the older texts comes about because they are written in a dialect that is unfamiliar to us.

If we can become fluent in a number of dialects we can get access to the knowledge contained in those theories and writings.

So, let's look at the idea of Drive Development and Ego Development. The key reference for this is Chapter 3 of Anna Freud's Normality and Pathology in Childhood.

1. Clarity on psychosexual stages

The psychosexual stages were developed by Freud in response to his work

with his first patients. He found that their symptoms were related to repressed loving or hating feelings they felt could not be expressed. As he learned more about his patients' histories, he found that they often had experienced earlier difficulties in these areas. He became interested in tracing back the development of loving feelings as an aspect of normal human development. In so doing he elaborated aspects of childhood sexuality, and organized his findings into a set a developmental stages. The psychosexual stages you've heard of - oral, anal, phallic, Oedipal, etc - make up the first stage theory of normal human development.

Today we know so much more about the changes that occur in the developing child. We can think of the first stage theory as describing a single line of development - libidinal development. This pertains to the establishment of a capacity to love, and to see others as full subjects. The names of the stages refer to specific areas of the body. Again, today we know so much more about what occurs in a growing body, so here too we should think of infancy as including oral development, without casting all aspects of that development as "oral."

In the Three Essays on the Theory of Sex, Freud describes the oral stage in part as a time when the child finds pleasure through activities of the mouth. We can observe that feeding, thumb sucking, placing objects in the mouth, etc, support this view. We also know that the infant is developing a relationship to their entire body, and is working towards establishing a capacity to be regulated and soothed. This aspect of infancy is better described as regulation, not oral pleasure. When referring to the oral stage today, it should be assumed that there are multiple lines of development occurring at this time, not just the development of pleasure moving through bodily zones.

As I mentioned, another aspect of libidinal drive development is the move towards seeing others as whole people, or "whole objects." When Anna Freud, for example, discusses drive development, she typically refers to the stage at which the developing child can see others as whole objects, and the total way of relating, specifically toward one's parents.

Taking the libidinal stages of development, we see the child moving from

seeing the parents, especially the mother, as a source of regulation, and feeling of rightness in the world, into a gatekeeper to the outside world, to testing whether they are able to respond to the child's feelings or communications, into an audience for one's sense of value and worth, into a rival for the other parent's love, and so on. If a child is behind in this development in comparison to their peers, or if an adult presents with difficulties in one of these areas, then they are considered regressed in this model. If development is expressed in a metaphor of forward movement, then a retreat to an earlier form is expressed as a regression instead of progression.

2. Clarity on Ego Development

If Drive Development, specifically libidinal drive development, refers to the growing child's changing capacity to relate to their parents, then

Ego Development refers to the growth of psychological capacities in the child. We can think about all the ways in which a person moves towards maturity and away from dependence. Some of these ways of growing pertain to normal maturational processes and their outcomes. For example, perception, speech and language, using the muscles to move about. Hartmann called these the "conflict-free" spheres of ego development. However, any aspect of development can be affected by conflict, and can be taken up in an effort to communicate that conflict. We should understand "conflict free" as meaning borne from a maturational process instead of an outcome of internal conflict.

We can think of Ego as the part of ourselves that has to contend with the existence of an outside world, and the demands associated with living in it, among other people. We are driven to connect with others. But those others are real people with their own subjectivity, their own dreams and history. Inside, our wishes and impulses are not rational or realistic. When we talk of the Ego we are talking of our struggle to satisfy our inner needs and wishes within the constraints of external reality and the lives of others. Over time we hope to see an increase in one's capacity to take in the perspective of another person. To

demonstrate self control. To tolerate a separation. To know the difference between an impulse from our inside and a stimulus from outside ourselves. If you made a list of all the ways we grow normally, and a second list of all the things we need to be able to deal with to conduct ourselves in a mature fashion, those lists would comprise what we mean when we talk about Ego development.

We talk about even or uneven development in two ways:

In one way, we take note when the aspects of ego development are not in harmony. For example, the child may be age appropriate or even advanced in many areas, but "regressed" in one or two particular areas. We should become curious about how this came to be, and also know that the child will have some subjective reaction to this imbalance.

Or, we can think of the relative strength of the ego vs the id, or the drives. In an ideal situation, we would expect the ego to develop in harmony with the changes in the way a growing child relates to others [their drive]. When Anna Freud talks about conflict between id and ego, she refers to the lag in our capacity to deal with our new ways of relating to others. Contemporary readers find this confusing because she is using jargon that synthesizes several complex ideas, and then describes these terms as having agency and in an actual conflict or a horse race. Bundles of capacities and impulses become personified or animated. To make this useful, we need to break down these concepts into what they mean in plain English.

B. Attachment and Parent Child Relationship

A discussion of drives and ego development is part of what we call the maturational process. Development is made up of the combination of two ideas, the maturational process and the facilitating environment. That is, we are wired to grow in certain ways, but this growth can only occur in the right context, specifically the human context. We turn now to a discussion of the facilitating environment, and the parent child relationship in particular.

The human infant, in comparison to other animals, has a much longer period of dependence, and because of this the parent child relationship has a great effect on one's development. Let's look at how a few important theorists have considered the development of the dependent child. We will consider how each gets something right, and focus on similarities rather than differences between them. A focus on differences creates an obstacle to integration, and nudges one toward choosing a club rather than developing a well rounded understanding of the developing child.

Margret Mahler considered the phases in a child's move from complete dependence, to a period of separating and becoming an individual. John Bowlby looked at this period from a different point of view, noting the child's need for a sense of security, which is necessary if the child is to start to explore their world. Both of these models see the dependent child as needing their parent to meet their emotional need in a time of immaturity.

Winnicott considered stages of the infant's dependence on their parent. He described the first three to six months of life as Absolute Dependence, because not only is the child dependent on the parent, but the parent can focus on little beyond the dependent child. In the period of Absolute Dependence, the child calls forth an attitude he calls Primary Maternal Preoccupation, which is another way to say that the parent can focus on little else, and couldn't even if they wanted to.

We consider the demands the child places on the parent as needs, not wishes or simply pleasure. They are needs, because if they are not met, the child must make drastic adaptations which could have long lasting effect.

We consider that if the parent is to be able to meet these needs, they will need to see their child accurately, as a person in their own right. They will need to prioritize their child's need. When a parent needs to protect themselves from overwhelming pain or traumatic experiences, there is a risk that the child will be located within these blind spots, and thus not have their needs met.

As the child establishes an understanding of their parents' patterns of reliability and attuned responses, they establish expectations of others they will

meet and relate to. We can call this a Working Model of relationships. When we meet with the child in a clinical setting, this working model can show itself to us in the transference.

C. Summary

We can summarize normality with a set of observations about the nature of children.

1. Children are built to connect to others. They are driven to do so. Other people are essential to the child meeting their needs to grow.

2. Children's feelings are bigger than their capacity to deal with them. To them, their feelings are the truth, and your reason is a foreign language. They aren't sure they will be able to manage their loving and angry feelings. Their angry feelings might hurt others, send them away, or destroy the whole world.

3. Children are very aware of their dependent status. They need to trust that protectors will be nearby. They worry that their needs will be so overwhelming to the grown-ups and they will leave. If the child can feel security, a basic trust, they can then go explore the world, confident that they may return to their base.

4. Children aren't sure they will be able to control their body, to not hit, to make it to the toilet, to not fall apart if they get hurt.

5. Children want and need to be recognized and valued for who they are. When they feel that someone is seeing them inaccurately, or not at all, they feel

dropped.

6. Children want competent people keeping them safe, protecting them from a dangerous world. When parents protect children, the children will make sure they mean it. As if to say,"If I cause a fuss, if I cry, if I call you the worst parent ever, will you still protect me?"

II. Understanding Pathology

The following view of pathology follows naturally from the view of normality just presented. In this view, pathology is a result of unhealthy development. It is not about having an illness, nor is it based on having incorrect ideas or behavior. Rather, it sees pathology in part as an adaption or a response to a lack of a healthy facilitating environment, with normal or exceptional needs unmet.

We will review a method for conducting an assessment of pathology, and then turn to a method for formulating our understanding into a diagnostic profile.

A. Assessment - interviews with the parents

Part of an assessment plan is to choose the order of the steps, like cars in a train. In this method, the clinician starts with a phone call with the parent who called. In this call, one notes any unusual difficulties in setting up the first appointment, and the ease with which one can schedule the appointment with both parents. Of course, there are always cases where one should not start by meeting with the two parents together. But if this is possible, then it is best to start this way.

In the first appointment, the goal is to demonstrate that you understand the problem that they are calling about. At some point near the end, you will put it in a simple sentence or two - "you are concerned about X and are not sure what

to do about it," for example.

It is expected that parents will have mixed feelings - good and bad - about bringing their child to therapy. The main reason why a child case fails is because the alliance with the parents is not strong enough. So one purpose of the parent interviews in the assessment phase is to increase the parents' good feelings toward the therapist, and address and transform as many of the negative feelings as can be done. The Novicks' book Working With Parents Makes Therapy Work is a key text here.

The alliance with the parents is strengthened when the parent reduces their sense that the therapist blames them for the child's troubles. It is strengthened when the therapist has empathy for the reasons why a parent has adopted a less-than-developmentally-optimal parenting style. It is strengthened when the therapist finds, acknowledges, and communicates with the healthiest part of the parent.

This model of assessment calls for three parent interviews before meeting the child. The number may be less than three, and occasionally more, but three is the basic model. The second and third meetings are with each parent individually.

In the individual meeting with the parent, the therapists asks for their reactions to the first meeting, and follows this line as long as it produces material. Then the therapist turns to whether the parent feels they left out anything important in the first meeting, and invites them to fill them in now.

The final section of the individual parent interview is to gather information about how the parent themselves grew up. Rarely, a parent will protest that their child's problems have nothing to do with how they grew up. More frequently however, they provide this material freely. This is because they too have a normal wish to be understood, including by their child's potential therapist. Second, the parent has some understanding - usually unconscious - that their childhood experiences have quite a bit to do with what is going wrong. The therapist may feel confident to share with the parent a connection they observe in the parent's own experience as a child and their wishes surrounding their role

as a parent.

While listening to all this material in the three parent interviews, the therapist keeps a few theoretical concepts in mind. We remember that the role of parent evokes one's experience as a child. One parent-child relationship brings up another. Aspects of one's childhood experience may have made strong impressions, with strong associated feelings and feelings about oneself. For example, a parent whose privacy was never respected as a child may place a strong value on privacy. They may project this attitude onto their child and see it as a general parenting rule. They may be blind to the fact that their child hungers for them and wants them to be more involved in their life.

Sometimes a parent has experienced extreme deprivation or maltreatment, resulting in a need for a dissociative defense. This creates a persistent blind spot behind which severe parenting deficits may lie untouched. Selma Fraiberg called these Ghosts in the Nursery, ghosts which are unseen and unconscious yet exert a strong influence on parenting.

The outcome of the interviews with the parents, when successful, is a tip of the scales toward positive over negative ambivalence, a sense that the therapist understands the problem from the parents' point of view and experience of themselves as wishing to be competent and loving, and a sense that their child meeting with the therapist will be a way of providing for a genuine need of their child's.

B. Assessing the child

Once the therapist and the parents feel ready to see the child, those clinical interviews can be scheduled. Below, we will review a diagnostic profile that will help the therapist collect assessment data. But here we describe the setup of the assessment situation.

We will remember the parents' views of their child. By doing so we will notice discrepancies between what they experience and what we observe. We

may find evidence of a projection - something the parent attributes to the child but really comes from their personal experiences. We may also find blind spots - areas of need of the child that remain unseen by the parent because something about it evokes painful feelings in the parent. We also remember the concerns and troubles that the parent noted in their interviews. I will probably directly ask at some point about these troubles, but mostly we just visit with each other. The three of us - the child, myself, and the troubles in the field around and between us. If I give my patient my complete attention, then I am not consciously aware of other things like the parent's demand, theory, or my other patients or my own troubles. If I realize I am thinking about these I refocus on the experience of sitting with my patient, and grow curious about their experience.

This way of working, this construct, has a way of allowing the unnamed trouble to show itself. The trouble has no secret name - rather, it is not yet named. We don't create it together, we co-discover it and name it. Like two detectives creeping down a long dark hall with our flashlight beams lighting our way.

The first case histories had the structure of a mystery story, with a solution at the end. As if we dug up a treasure chest, opened it, and read aloud the message contained within. But it doesn't really work like that.

Instead, the child spends some time in the room and does something, and we do something, and probably say something about what is happening. After they leave, I'll write some things down. I may talk with a consultant or colleague about it.

What's important to note is when the child plays, the content is action, feeling,

body sensory experience, relating, images, but not so many words. **Play is the child's dramatic and artistic rendering of troubles they don't understand.** Most of the words are produced by me. One part of me says them, and another part listens to what was said. Or, one part writes some notes afterward, and another part reads what was written. Or one part speaks to a consultant or case conference, and another part hears and understands. The trick is to describe the play in language to see what unconscious understanding you add to it.

C. Anna Freud's Diagnostic Profile Updated and In Contemporary English

Think of the difference between reading Shakespeare and going to see it performed. If the words on the page are unfamiliar, then it is difficult to catch the meaning. But when it is performed by actors who understand the story, their movements, diction, and emotion lead you to the meaning.

Psychoanalysis is an evolving body of knowledge of how we grow in healthy and unhealthy ways, and the meaning we make of our own life and the lives we encounter. There are obstacles to taking in and mastering psychoanalytic knowledge.

One is that our theory is written using the format of scientific language, and makes use of particular jargons. The jargon doesn't form a comprehensive whole because different jargon is used by different schools intentionally. Additional knowledge may be presented as a competing hypothesis rather than enrichment of our understanding.

Another obstacle is that knowledge is continuously revised, with the new knowledge sharing a bookshelf with the old. The new and the old may not fit together in obvious ways and so we have trouble taking it in.

We may also not wish to understand how the ideas all fit together. Psychoanalytic knowledge can bring up strong feelings, and painful ones. Ideas

are learned from teachers who we may like or who bother us, or we may be part of a community that uses a certain interpretation of the data, and membership in that community may be important to us.

Because of these and other reasons - a tradition of revision, use of jargon, etc - there is danger in psychoanalytic knowledge becoming lost. As we look at the diagnostic profile, we will review the time tested, constructive and useful knowledge from across psychoanalytic schools that pertains to treating children and in plain English, with minimal jargon.

Anna Freud's diagnostic profile has been repeatedly referred to as the go to organizing structure for understanding and diagnosing a child patient. However, contemporary clinicians have trouble finding the profile useful in understanding their patients. Below I have reviewed the profile, updated the language to reflect contemporary ways of speaking, and bring in newer sections that relate to additional knowledge about children and their development. You can think of much of this as a set a questions to remember, important points to consider. You may not have good data to answer all of these questions.

1. Reason For Referral

In the own words of the person who is calling, why are they calling you? What do they see as the problem? This is what they believe, at this time, they are hiring you to help with. You should remember this because the person calling certainly will remember it.

2. Description

What does the child look like?
What are their demographics?
What is their manner? That is, how do they seem?
How do they hold their body?

How do they talk?

3. Family Background and Personal History

The child's history starts when:

The parents MET
Became a couple
Came to have a child
Pregnancy
Birth, and so on

Parents' personal history

4. Significant Events or Influences on the Child

Parent Loss
Illness
Immigration
Trauma

The ACES:

- Physical abuse
- Sexual abuse
- Emotional abuse
- Physical neglect
- Emotional neglect
- Intimate partner violence
- Mother treated violently
- Substance misuse within household

- Household mental illness
- Parental separation or divorce
- Incarcerated household member

5. Assessment of Development

We assess development by drawing from the parent report, and other reports, and also from our direct clinical observation of the child. In making an observation, it is helpful to remember that if you see something, it is there. We can first determine whether we are seeing something, and can ascribe meaning to it later. If we see water falling from a sky filled with dark clouds, we should be comfortable noting that it is raining. We should not feel the need to look for other explanations that have no evidence. We can draw conclusions about the climate or geography later.

5a. Relationships with Others

1. Libidinal Drive

We look for evidence of what psychosexual stage the child's behavior demonstrates at this time. For example, to consider the stages chronologically, does the child:

Use others for regulation
Use others as a secure base for exploration
Use others to test whether they are able to respond to the child's feelings or communications
Use others to build their sense of themselves as worthwhile, valued
See others as rivals, etc.

We also consider the extent to which the child is relating to a part-object or

whole object. Do they see others only insofar as others meet their needs? Or are they aware that they have an effect on others, that they are dependent on others, and demonstrate some responsibility in this area?

2. Attachment

To focus in on one of those listed above, a child may tell you much about how secure they feel in their attachments to others. You see this in how they separate from their parent before coming to your office. Are they able to? Do they cling? Do they walk away easily without saying goodbye or looking at the parent? Do they seem able to explore the room? Does the child see the parent as a secure base from which to explore the world, or might the parent run away and abandon the child? Does the parent care enough to protect the child?The answers to these questions don't necessarily line up with a specific meaning, because meaning is dependent on context. But the observations are valid and should be noted, with the meaning to be determined later.

3. Rivalry [Oedipal Development]

To focus on a second, we also observe the child's communications in the clinical assessment session about their sense of rivalry. What is their interest in their parents' relationship, and the nature of the family? Rivalry may be seen in the home, at school, and possibly with you.

5b. Feelings About Self ["Narcissism Line']

In psychoanalysis we have distinguished between our loving feelings toward others [libido, above] and those toward ourselves [narcissism]. These are related, but it is still helpful to separate them conceptually and clinically.

We want to see whether the child feels they are special to someone, that they

are valued by their family and friends. What can we observe about their self-esteem, how they feel about themselves and the worth they ascribe to themselves? Have they internalized a sense of their own goodness?

Do they seem to reject feelings associated with their normal need for others, and appear too independent? Is there notable material on how they can go off on their own?

Do they appear grandiose, seemingly without ways to cope with their smallness, expressing about how big and powerful they are?

5c. Aggression

Just as narcissism is the opposite of libido with respect to who it is directed towards, aggression is also an opposite of libido, in terms of whether it is a loving or hating feeling.

We are interested in whether the child demonstrates aggression, and how they do so. Who is it directed towards? It is directed verbally in their stories, toward you, or toward the toys?

We also think about the meaning of the aggression. Is it connected to rivalry, lack of self esteem, loss of regulation, etc? In other words, think about hostility in the same set of stage categories you did with the loving feelings.

Or, does it seem to be a counter attack towards an overwhelming world? When a child feels the demands on them is too great, they feel attacked or abandoned. They may worry that their destructiveness is too much for the world or their caregivers. And so what appears to be aggression is meant to be defending oneself.

5d. Ego Development

Moving from the drive side to the ego side, we can think about emerging maturity and observe whether the child appears age-appropriate in the following areas. Consider whether by observation or by report the child has a notable deficit in one of these areas:

Language and Speech - making words and thinking in words

Motor Development - using their body to get about the world, and having a mental image of their body and others'

Self Control - stopping themselves from certain behavior

Perspective Taking - seeing a situation from another's point of view

Reality Testing - knowing whether a feeling or idea comes from their feelings and fantasies inside or the outside world. How do they attribute causation?

We also note whether the child's development is even or uneven across domains. Psychological testing may show this, or it can be determined through observing these areas above. Some degree of disharmony across the lines of development is normal, but a great difference is felt by the child, and they can have bad feelings about themselves in relation to this.

5e. Defenses

Defenses can be against one's own impulses or a denial of our sense of how the world is for us. In both cases, a defense is a reaction to something that is unbearably too much, or unbearably too little.

We can consider the expectable anxieties of young children and review them like a checklist. Some of these, found in Alicia Lieberman's Emotional Life of the Toddler include:

Fear of losing the parent's love
Fear of a problem with one's body
Fear of the unknown
Separation anxiety
Developmental demands - e.g. Toilet training
Problems with regulation - e.g. Sleeping at night
Sibling Rivalry
Parent conflicts

We consider whether the defense seems effective. Does the child find relief from anxiety by using the defense? If the parent is reporting it, though, it is likely not working well for the parent.

Following our review of normal drive and ego development, we consider whether the ego defense is strong enough for the drive. That is, is it well matched to address the concern? We can acknowledge that we are using a quantitative metaphor to measure meaning, yet it does still work.

As part of thinking developmentally, we consider whether the child is making an attempt at repair, and if the child shows feelings of constructive guilt. Does their choice of defense suggest they are forming a conscience, which is related to the idea of superego development.

5f. Behavior and Symptoms and Character

Be sure to take note of all of the symptoms and troublesome behaviors reported by the adults. Also, see which if any you observe on your own. Think

of these as little clues the child's unconscious is throwing your way. Maybe the child is throwing up a red flag just so that we know there is something seriously wrong here. Or they are pulling the parent to do something the parent doesn't want to do. Or they are trying to tell us in disguised form something they believe we don't want to hear, or they don't want to acknowledge because it is too painful to them.

5g. Fantasy Material

Take all the stories the child tells you in their words, play and behavior. Turn their play and the story of what they are doing into a fairy tale. Then read the fairy tale and decide what you think it means, based on what you know of the child story-teller.

Another gimmick to help you, is before the child tells you about people in his life, pretend that he prefaced this with "I had a dream in which…" this helps you see the narrative meaning of this communication.

In a similar way, when the child is in the waiting room, and in your room, pretend they are an actor in a play, and you are interpreting the meaning of the narrative.

You can practice this during the boring parts of movies, when nothing seems to be happening. When a boring part comes, ask yourself what is the meaning of this scene? What is the writer or director trying to communicate?

D. The Diagnostic Write-Up

Given an understanding of what healthy development is, what their child's history is, and what we are being presented with, and after collecting the data described above, we are in a position to come up with our initial working hypothesis. The hypothesis should address the question - what went wrong here? How did this become the developmental path for this child?

Try to answer that question in plain English, like you are explaining it to a colleague who doesn't know the case. Pretend you are jumping into a cab to the airport but first quickly need to update the person who will be managing your case. This plain English explanation is a good rough starting point. It will bring up questions and you will answer them. Don't explicitly try to put all the assessment data into the picture. If you become acquainted with it, some story will emerge. Tell it, and better yet write it down. This will show to you what it is you believe is going on with this case.

The written down plain English explanation is your first part. Then go back to the beginning and start answering the questions. Either you know the answer or you need to think about it a minute, or you really don't know. Then move on.

When you get to the bottom, back to your plain English story of how we got here, review it and make revisions that occur to you. If you're doing this for an assignment in a training program, you should put it aside a week. Then come back and read it and think about what theory the "author" [you] seem to be using and write about that. You now have a complete working draft.

III. Technique [and theory]

Starting with the benefit of a working hypothesis, and once the therapist has established a working plan with the parents, the therapist is ready to start sessions with the child. Much like the assessment sessions, when one was gathering information, the therapy sessions provide a space where what is on the mind of the child can be communicated.

We can remember how we used fantasy material in the assessment. Prefacing the statements with "I had a dream in which," and seeing the play as a fairy tale and their behavior as theatre. Some see the therapist office as a field in which these play events unfold. Others relate it to the creativity in the emerging

relationship between mother and child, as a transitional space between merger and individuation. In this model, the therapist pays close attention to the feelings the child expresses and "holds" the child by providing a space where it can be expressed, including indirectly through the play. The therapist in any case comes to form their own idea of their space and what happens in it.

Likewise, a therapist develops their own style about how and when to interpret. During play, the therapist may simply narrate what they see, and then listen to what they hear themselves describing. They may name the feelings the characters must be having. They may speak some dialog for a character to show the child they understand what the meaning is. They may also choose to connect what they see to what they know the child is dealing with in real life, although this type of interpretation is usually for the benefit of the therapist themselves. It reveals the limits of their understanding and checks with the patient to see if their idea is correct. Klein found that this explicit interpretation is met with increased capacity to deal with the feeling, while others note when this disrupts the play. Often we find, with children as well as adults, that waiting is best because the child then does their own work of interpreting and sitting with the material.

When a child does their own interpretive work, their ego capacity is increased, or their self is made more cohesive, etc. They find new, safe ways to tolerate their feelings and self-knowledge. They also develop a better understanding of themselves, and can present this to others with more clarity.

To make the most of these gains, they need to be brought back to the parents so they can make use of them at home. Children want their parent to understand

them. The child needs the parent to provide a facilitating environment. The parents want to feel optimistic about their child's future and to feel competent. So you fill in their gaps of understanding. When they come in, have them talk first, tell them you want to hear what they have to say and their observations are so helpful to you. Their concerns will emerge and you will do your best to help out.