Doing Child and Adolescent Psychotherapy

Adapting Psychodynamic Treatment to Contemporary Practice

Second Edition

Richard Bromfield, Ph.D.
Doing Child
and Adolescent
Psychotherapy
Doing Child and Adolescent Psychotherapy

Adapting Psychodynamic Treatment to Contemporary Practice

Second Edition

Richard Bromfield, Ph.D.

John Wiley & Sons, Inc.
For Margo, friend and mentor
Contents

What’s New to the Second Edition ix
Preface to the First Edition xiii
Acknowledgments xv
To the Reader xvii

Part I The Essentials
1 Easy Does It: Beginning Therapy 3
2 Can I Help You? Evaluating the Child and Offering Treatment 15
3 The Not-So-Magic of Therapy: How Therapy Works 29
4 Do Fence Me In: The Bounds and Limits 47
5 Tell Me Where It Hurts: On Talking and Querying 63
What’s New to the Second Edition

Almost 10 years ago I wrote a guide to child therapy. I worked hard, then, to make the book relevant, timely, and thorough. But a lot has happened over the past decade. The economics of mental health, a euphemism for managed care and insurance companies, have grown from supporters of what we do to dictators of it. Even as we meet with our young patients in the privacy of our offices, we feel those bureaucratic beasts breathing down our necks. If, just as Watergate’s Deep Throat advised, we “follow the money,” we see the profound influence that these entities have had on the important work we do. Hospital beds and inpatient settings are disappearing. Every day, child therapists are asked to do more with fewer resources in less time. Paperwork, legal matters, and compliance with state and federal regulations have, like greedy little Pacmen, rushed in ahead of patients to gobble up clinicians’ time.

But the shrinking dollar for child treatment has done even more than stress child therapy and its providers. Through the subtle powers of the
mental health market, our field has started to join rather than fight. Short-term models of therapy and evidence-based interventions have ascended. Under the strain of financial realities, clinicians find it harder to stick to what they believe or are downright prevented from doing so. However precious their mission, child therapists work for a living just like everyone else. To use a weak analogy, a house might need scraping, a primer, and two final coats. If we are going to be paid for only one final coat, how many of us can afford to do it properly? The discrepancy between ideal practice and what really exists has expanded into a Great Divide.

Yet it would be too easy to dismiss these new treatments and their research as nothing more than quick and dirty ways to save a buck or, a bit more generously, as means to survive in today’s more competitive environment. While the pursuit of cheaper and quicker treatment methods might be driven by other than benevolent forces, the men and women who are studying those treatments genuinely want to help children faster and more effectively. There is no virtue in getting better slowly. Anything that alleviates children’s pain and promotes their growth in less time is to be honored and adopted.

Real differences exist, and we won’t shy away from them. We live in a new world order, however, one that we have to and should reckon with. This new and second edition of Doing Child and Adolescent Therapy will take up this challenge—holding on to all we know about the value of relationships, personal meanings, and inner worlds to children, their difficulties, and their recoveries—while heeding what we are learning about other ways to help them and their families. At times, we will change our minds, sometimes integrating and accommodating. At other times, we’ll acknowledge the debatable truths of both sides. And then, many times, we’ll stay put, not stubbornly or out of ignorance but for what we judge to be good reason.

To be a contemporary guide to child therapy, my book will need to do more, and it will. Its sturdy spine, centered around the therapist–child relationship, will follow a timely trajectory that spans from the initial referral call, through early assessment through the middle substance of therapy on to termination. The first third of the book, The Essentials, will address how we begin a treatment, how it works, the mechanics of therapeutic powers and need for limits, and the techniques of therapeutic talk and query. The middle third, Techniques and Tools, in pragmatic
and lively terms will detail the use of puppet play, toys, games, and art in child therapy, paying special attention to the ways we balance play and talk. Here, we’ll also deal with the exceptions of therapy, such as gift giving, disclosing, and bending the framework. Despite its lazy title, the final section, The Rest, ambitiously tackles parent guidance, family work, reluctant patients, crisis, medication, diversity and cultural dynamics, managed care and evidence-based treatment, and concluding a therapy—a miscellany critical to child therapy.

I’ve aspired to address all that matters, writing in prose that is clear and engaging, that shows as much as tells, and that conveys the real experience that child therapists will immediately recognize. In the end, only you will judge the relevance of this book to your precious work as a child therapist. I hope it proves itself worth your time.
Preface to the First Edition

We child therapists need no convincing of the seriousness and arduousness of our mission. In our most splendid moments, we see our young patients heal and go forth on solid ground toward happier and more satisfying lives. At other and more usual times, we help children and their parents get through another day or week with less mishap and destruction or, perhaps, leave our offices with a little less pain and suffering than when they came. And sadly, there are the darkest times, when our best efforts do not help at all.

Our purpose is not, as some observers think, simply to be a friend or confidant to the child. That would be easy. As I’ve written elsewhere (Bromfield, 1992, p. 6), children’s playing in therapy is much more than mere “fun or pretend-to-be-taken seriously.” What we do is complex, wearing, slow, and uncertain in its progress and outcome. And much of what we do we do alone—without help, confirmation, or encouragement,
often against the odds or under disapproving eyes. Done properly, being a child therapist is hard and noble work.

This book is dedicated to that worthy and challenging purpose. With vivid clinical material and personal candor, the theoretical essence and practical essentials of doing child and adolescent psychotherapy are laid out, from the referral call to the last good-bye, capturing the intricacies and subtleties of children and their therapies in their biggest and smallest ways—and everywhere in between. Whatever aspect of therapy is discussed, our eyes and ears are aimed toward what is transpiring in the child, in the therapist, and in the space they share. And whatever the clinical situation being examined, a slow and steady focus on the building and meaning of relationships—between child and family, child and world, child and therapist, inner and outer experience—ever reigns supreme in these pages. The belief that the therapist’s most powerful, if not sole, therapeutic tool is himself pervades every nook and cranny of the book and serves as its foundation.

I hope this intimate and pragmatic guide to child psychotherapy renews, fortifies, and enriches the important work you, as child therapist, pursue every moment of every clinical hour.

—RB, 1997
Acknowledgments

How does one thank the near-countless colleagues, supervisors, supervisees, and patients who have taught me hour by hour since I first walked in, on wobbly knees, to meet my first child in therapy? I hope those who have taught me best can see and hear themselves in these pages. Gratitude goes to Patricia Rossi, my editor at Wiley, who from a small correspondence we had years ago held on to her belief in a readable book to integrate psychodynamic child therapy with the realities and resources of modern health care. And a special thanks go to Dr. Gene Beresin, whose review of this book’s first edition, a decade ago, served as a compass for its dramatic changes, revision, and enrichment.
As I wrote previously, “I use children to mean children and adolescents of all ages. If I need to define a child or group more narrowly, I use other terms, such as infant, toddler, adolescent, or first-grader. I refer to those I see in therapy as patients (though I appreciate the sentiments of those preferring the term clients). When speaking about children or therapists in general, I randomly alternate male and female pronouns to avoid the intolerable monotony of he and she, her or him” (Bromfield, 1992, p. 9).
Doing Child and Adolescent Psychotherapy
Part I

The Essentials
Beginnings are important, arguably critical. A small misstep can detour us unnecessarily; a large enough one can wholly derail the journey. At the very least, the first steps, the ones from which all other steps follow, form the foundation on which a therapy and the essential relationship within are built.

We begin with the parents. They are the ones who usually choose, arrange, and pay for a child’s psychotherapy. Consider the challenge facing the mothers and fathers who call us. In a handful of minutes, they try their best to present an enormously complicated, painful, and often embarrassing situation to a complete stranger who purports to be some kind of expert on matters of children and families. As former students, we know the intellectual demand of case formulation. Imagine adding the heavy measure of worry, self-blame, and hopelessness that parents feel.¹

Whatever parents’ issues, we try to listen patiently. If we’re rushed, we say so and offer a better time in the near future to talk. Sensitized to
the difficulty of their call, we try to help parents tell their story—asking
helpful questions of the timid, slowing the speedy, organizing the ram-
bling. We do so not only to foster a connection but also to see what the
problem is and whether it is one that we can help solve.

A few more moments on the phone can convince us that we are not
the appropriate clinician and might inform our making an effective refer-
ral elsewhere. Or they can help us to distinguish true crises from entitled
demands or reveal the basic motive for the call (e.g., seeking not therapy
for the child but evidence to battle for custody). Our time is well spent
on the first call and is in everyone’s best interest. It preserves our hours
to do treatment. It saves the patient’s time and money, and, by helping
get the child to the right help and person, it can prevent the emotional
toll of prematurely investing in the wrong therapist.

When sensing a mismatch, we gently—so as to minimize any feel-
ings of rejection—describe how children, particularly adolescents, tend
to connect most with the therapist they see first. Meeting with us, we
further explain, could obstruct connecting with a second therapist. For
many parents and children, meeting a therapist and sharing their stories is
both draining and bonding. It is almost always best to save the powerful
carly meetings for the therapist of final destination (though sometimes
clinical conditions or the restraints of health care systems require patients
to see a series of practitioners on the way to their eventual clinician).

While we assess matters, so do parents. In many instances, they shop
for a therapist even as we speak. What do parents look for? All sorts of
things. Facts, such as what we do, what we charge, what kinds of insur-
ance we accept, whether we have openings, where the office is. Do we
listen and seem to care? Do we sound kindly and patient?

Many parents have begun to form impressions of us even before hear-
ing our voices. If we’ve come highly recommended, there may be halos
around our heads. While inflated views of what we can do make for
casier and enthusiastic beginnings, they can just as often backfire, leading
to disappointment and impatience, even premature endings, when our
work does not produce big enough or fast enough results.

Conversely—and more commonly in today’s busy and tight marketplace—
parents consult us because of insurance plan constraints or matters of dis-
tance and scheduling. To one disgruntled mother who saw me as her distant
second choice, I said, “You’ve mentioned several times having to stick to
a list of providers.” Putting such dissatisfaction on the table helped her to
speak her mind concerning her ultimate doubt as to whether any therapist could help. Sharing this thought with me gave her a bit more confidence in the process and led to her giving me a fair chance to prove myself with her and her daughter.

I see the purpose of the initial call as deciding whether future contact with me is likely to benefit the child. If it makes sense that we go no further, I aspire to give parents a good experience with me as representative of the mental health profession so that they will persist in their quest for help. And when we do agree to meet in person, this call has gotten us off on surer footing, the work well begun.

FIRST MEETINGS

With younger children, I typically offer parents the option of meeting with me first without their child. This provides an opportunity for the parents to speak freely and check me out. I suggest that parents of elementary school children accompany their child. In contrast, I urge parents to let their teenage children come to the beginning hour by themselves, explaining that doing so counters the common adolescent tendency to mistrust and reject the therapist as another arm of parental authority. I bend, however, to comply with parents’ good reasons for other arrangements (e.g., a ninth-grade girl who fears going anywhere without her mother or including a very young sibling who can’t be left alone in the waiting room). Regardless of the child’s age, in the course of the initial meetings I try to meet with both child and parents, alone and together. This early negotiating, structuring, and educating concerning who should come begins to show parents how therapy will work and proceed.

Making our patients feel safe—the absolute first requisite to any worthwhile course of therapy—begins in the earliest moments. Do we take a minute to greet everyone who has come with the child? Are we kindly? Do we smile sincerely? Do we look the child and his mother in the eye? Or do we appear to be just doing a job, grudgingly serving the next customer? Do we ask how they’re doing, then turn away and head into the office before they’ve answered? Giving a disorganized mother a few minutes to gather her children and their belongings may accomplish more than rushing her into the office. By themselves insufficient to ensure good treatment, these civilities—done in good measure, neither
to feign sympathy nor to manipulate—convey a sense of us as real persons and help our patients make the transition to the world of therapy they’re about to enter.

When we go out to meet new child patients, some zip past us like Speedy Gonzalez, rifling through our toy boxes or our desks before we’ve said hello. A majority of them follow the lead of their parents who, in turn, follow ours. Others dally, coming at a snail’s pace out of fear or to show who’s boss.

Sure that I, at this point, am sure of little, I tend to stay out of the line of fire. I let parents and child struggle their way into the office, reminding myself that they somehow manage their lives when I am not around. I do not force anyone to come in, for that is the quickest way to nowhere. My threats or tugs may get a reluctant child inside today, but there’s a good chance he won’t return tomorrow. And even if the child returns, she will see me as someone to be mistrusted, someone who has little respect for what she wants and does. Frustrating as it is, we generally can’t hurry what must come in its own time.

I can’t recall one instance when I’ve denied a child’s wish to come in with or without someone. Soon after we settle in, however, I turn our attention to the reasons for the demand, leading to a readjusting of who should and shouldn’t be there. While I never force a child to separate from a parent, I do note the desperate nature of her fear, a fear that will quickly take center stage in her therapy.

When parents can’t get a child to even come to the waiting room, I spend my time consulting with them, helping them to better understand and manage their child. Anything but a waste, such sessions prove to be at least as valuable as if the child had come (which usually happens the following week).

Once in the office, I say hello again. Children seem to appreciate this and sense that, under their parents’ and my watchful eyes, they hadn’t had a good chance to meet me. After a minute of quiet, an awful lot of children will spontaneously comment on what happened in the waiting room—the confusion, the nagging, the sibling riot—shedding light on their thinking and family dynamics. My simple interest in these observations goes further than any proclamations I might make to show my accepting attitude. The actual words, “You can say anything you want in here,” however exuberantly stated, have in themselves convinced very few children to spill the beans.
For the first minutes of our hour, I allow children to do as they wish. Some children calmly survey the place before taking aim at a particular object or toy. Some go right to my desk and begin drawing or ask if they may. Some come close; some stay as far away as they can. Nontherapists may be surprised to learn that many children sit in the chair opposite mine and begin talking of their troubles or wait for me to ask about them.

By this time, children tend to take notice of the office. Is it a place for children? This, perhaps, is the first question our child patients try to answer for themselves. Children from almost any background and class seem to prefer comfortable, cozy, and unpretentious. They prefer offices that look more like living rooms than hospital suites. Children tend to pick cluttered over immaculate, assuming that they will not be expected to be as neat in their play (and maybe even in their thoughts). And as we all know, a good selection of toys, building and drawing materials, and the like can be the quickest route to making children feel welcome (though, to be sure, it takes a lot more than cool stuff to earn their confidence).

Children will look around in an attempt to learn about the therapist. Fine furniture and original oil paintings will certainly give a different impression than ripped posters put out by the dairy council or drug companies. Happy childish pictures of sleeping bunnies and dogs dressed in people’s clothes may entertain but give a much different impression than more sedate and ambiguous pictures of roads winding into the woods or a lone bird flying into a muted seascape. Too many diplomas may impress one child, make a second feel inferior, and lead a third to perceptively wonder about the therapist’s insecurity. Children begin to read into what they see, but most of the time will keep it to themselves in the first hour, over time testing their hypotheses against the real thing, the therapist.

Of course, many child therapists don’t have their own offices. They, as students or as practitioners in a crowded clinic, use whatever room is available, however poorly kept or offensively decorated. Other therapists do their work on the road, hauling a bag of toys to schools and shelters. These therapists know best what the rest of us learn soon enough, that over the long haul it is our psychological presence, not our furnishings or things, that most matter to patients.

To learn and be able to help all we can, we need children and their parents to talk as openly as possible. To talk they must be comfortable. How do we accomplish that?
We might actively seduce them, by permitting them to sit on the windowsills, offering soda and chips, whatever the hour. We might alleviate the slightest hint of tension, theirs or ours, by laughing robustly at things that do not strike us as funny or that are unusually perverted. Likewise, we can compliment their parents’ choice of clothes or disclose that we, too, have children who wet their beds or disobey us. But these methods carry risk. Children and parents may get the wrong idea of what we do, thinking that we are there to appease them rather than to help them confront their demons and troubles.

Giving good ear is the earliest and most powerful method we have to engage parents and children. By good ear, I mean listening that is attentive and caring, listening that truly wants to hear what is being said, not that wants mostly to get another question and interview out of the way. While patients’ words inevitably evoke thoughts and feelings in us, we cannot really listen while planning our next question. Some of us nod and others “ahem” in understanding. But it is the substance of our listening that underlies these signs, the where and how it leads us, that shows parents and children that we are there and interested.

We may have a million questions; we ask a limited number. We ask them slowly. No one likes a third degree, even those who deserve interrogation. Too many questions can shut down the most open and cooperative of us. A handful of open-ended questions answered fully and with ample reflection and interaction will, on the average, inform us more than a lengthy laundry list of items to be asked and responded to Dragnet style.

We go cautiously and remind ourselves that not every piece of information is an invitation for further probing. Patients will often tell more than they wish to and more than they are comfortable with. Learning who our patients are takes time and cannot be jammed into one, two, or even three sessions (even if mandated so by a health care insurer).

Knowing also means knowing when we don’t know. On hearing of a dead grandfather, I’ve made the mistake of inferring sadness and regret, later learning from an embarrassed teenager that, in fact, she was glad that “that son of a bitch” had died, a pillar of his community who’d abused his daughter, my patient’s mother. I don’t assume to know what anything means to another person I’m just meeting. “Why,” I’ll ask a parent, “do you think Ben (a seventh grader) is so worried about getting into college now?” Or, “Why, of all the different issues you’ve raised, are