

Chapter 1

PSYCHOANALYTIC PLAY THERAPY

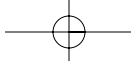
Richard N. Bromfield

As he did for so many other forms of treatment, Sigmund Freud laid the foundation for psychodynamic play therapy. His work with and thinking about his adult patients inspired new insights into the emotional development and experiences of children, particularly the profound relationship of children's psyches, bodies, and sexuality (1905). Although he clinically focused on adults, his informal analyses of his own children and treatment of Little Hans, a five-year-old boy with a horse phobia (1909/1955), and his working backward toward the early experiences of his adult patients, set the stage for the logical next step of treating children.

Hermine von Hug-Hellmuth, a teacher in Vienna, became the first to formally treat children with talk and play. In 1920, she wrote that "[t]he analysis both of the child and of the adult has the same end and object; namely, the restoration of the psyche to health and equilibrium which have been endangered through influences known and unknown" (p. 287). Initially treating her young patients in their own homes, Hug-Hellmuth appreciated the influence of family and saw children's difficulties much rooted in their parents' unresolved troubles. She also believed that conscious insight was not a requisite to a child's finding relief and help in play.

The most cited beginnings of child therapy revolve around Anna Freud in Vienna and Melanie Klein in Berlin. Both women held deep beliefs in the richness and complexity of childhood and development, appreciated the suffering that children know, and valued play therapy as a means for understanding and healing. The two women, however, disagreed on much else.

Klein (1932/1975) saw the child's play in therapy as the equivalent of adult's free associations and as the vehicle to making interpretations directly to even very young children's unconscious. She especially focused on what she perceived as the young child's experiences of abandonment, envy, and rage—concepts no less relevant today.



2 Psychoanalytic Play Therapy

Anna Freud's methods (1927/1974) were more measured, aimed at helping children come to consciously understand why they thought, felt, and behaved as they did, that insight inviting personal change. She respected the child's behavior and defenses as the child's best attempts to cope with their anxieties, traumas, life experiences, and growing up. Her lifetime of work not only recognized factors such as the child's health, living conditions, cognitive ability, and such, but she promoted parent guidance and school consultation as important functions of the child therapist. If Sigmund Freud was the father of psychoanalysis, then Anna Freud was child therapy's foremost mother.

BASIC CONSTRUCTS, GOALS, AND TECHNIQUES

The goals of psychoanalytic play therapy are many and include helping the child to suffer less (e.g., quelling anxiety and related bodily symptoms, lifting depression, and resolving complicated grief); overcome trauma; adjust to life events, such as divorce; cope with illness and comply with treatment; master phobias; be better able to attend, learn, and work in school; manage personal anger and aggression; and come to terms with a learning disability or physical handicap.

While these goals sound like those pursued by clinicians of other theoretical persuasions, the goals of psychoanalytic play therapy sometimes are more ambitious, aspiring to change not just a behavior or symptom but broader, deeper, and more essential aspects of the child and her ways of dealing with life and its ordeals. Psychoanalytic play therapy may be used to soften an overly harsh conscience in a child who won't give himself a break. It can help a child integrate various aspects of her personality or help her to master developmental tasks, such as separating and growing up, or adapting to puberty and its changes. Analytically-informed therapy can help detached or estranged children connect more to themselves and to others. This type of therapy is extremely good at promoting resiliency and adaptability, helping to reduce a child's vulnerability to psychotic and borderline functioning, especially under stress. It can help an inhibited child grow more spontaneous, active, and joyful; an impulsive child, more contained, reflective, and responsible; and a narcissistic child, less susceptible to wounded esteem and reactive rage.

Psychoanalytic play therapy intends to go beyond the immediate pain or difficulty and clear the way so that healthy development can resume from where it has been halted or detoured by external trauma or untenable internal conflict (neurosis). It also is effective in helping children who have real and significant limitations come to terms with who they are, helping them to develop more secure, adaptable, compensating, and self-accepting ways and attitudes.

How It Works

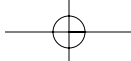
Therapy provides a troubled child a place safe from physical and psychological harm, where she can let her guard down sufficiently to explore her thoughts, feelings, and life. This type of therapy believes, along with the child-centered approach, that simply coming to know what she truly feels, thinks, and does can help a child to feel and function better, that is, to live in a more authentic way. But looking in the mirror with the lights on is difficult. By proving ourselves safe and trustworthy over time, we steadily convince the child that she has found someone with whom she can pursue and share this self-exploration.

But establishing a safe and accepting atmosphere isn't enough. The psychoanalytic play therapist strives to "therapeutically hold" the child (Winnicott, 1945/1975). Parallel to the way that a mother holds her baby, the therapist holds the patient—not physically, but psychologically. The therapist absorbs the excitement and distress that the child's mind and body cannot bear on its own. Moment by moment the therapist confirms the child's experience. This witnessing fosters the child's trust in what she herself feels and perceives, leading to her evolving a more genuine self, a keystone of psychological health. The therapist's noticing and admiring the child's steps forward renews enthusiasm and joy for her own growth and the risk-taking it requires.

Most of all, the therapist empathically listens and responds to the child. Being understood deeply, having your perspective heard, is itself one of the most powerfully moving experiences you can have and counters the painful, if common, sense of being unheard and ignored. In addition to being reparative in itself, the therapist's empathic stance facilitates clinical interventions that acutely meet the patient just where she is emotionally, neither falling flat nor overwhelming her.

Maintaining an empathic atmosphere also creates constant opportunities for the therapist to make "empathic failures" (Kohut, 1971), moments when he doesn't grasp some important communication from the patient, making the child feel painfully dismissed, criticized, rejected, humiliated . . . [fill in the blank]. By continually acknowledging our empathic missteps and allowing our patients to react to and analyze them, we as therapists enable those children to grow sturdier esteems under thicker skins.

Because the child is the one in charge of his own therapy, he can actively work on experiences in which he was originally helpless and impotent. In a fantastic reversal of fortune, the abused child can be the big grizzly who torments his once tormenter. The learning disabled child who finds every minute in school an assault on his pride can be the one who, in play, asks his teachers and peers questions they can't answer. Likewise, the bully can actively play out what really propels his sadistic behavior, his feeling little and powerless. Their reenacting in play, their



4 Psychoanalytic Play Therapy

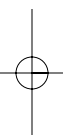
casting themselves this time around as the heroes and rescuers, can help children to master and grow beyond overwhelming situations and experiences.

Play allows the child to put her conflict into a symbolic arena (Irwin, 1983). A child who feels unable to confront her alcoholic mother can confront a doll standing in for her mom. That girl can speak her mind and even take revenge without fearing reprisal. The child also can project intolerable feelings about herself, putting internal conflict on the outside, making it a concrete reality she can wrestle with more comfortably (Jacobson, 1954). Instead of being tormented by his own conscience, a good boy who feels guilty over what he's thinking about can stage a battle between the good guys and the bad. At its most basic, psychoanalytic play—like most play—permits the child a forum in which she can face herself, her conflicts, and the people in her life from a psychologically safer distance, hence, more fully and openly.

Although a child is still very much in the midst of her childhood, her development, and the context of her family, psychoanalytic play therapy recognizes her wholeness as a person. The psychoanalytic therapist appreciates the role that even a young child plays in her life. What, we wonder alongside the child, do you contribute to your problems? What have been your ways of coping with an imperfect home life or a difficult teacher? We sensitively move the child toward seeing how she copes, defends against, and compensates for stresses—whether they come from inside or outside—cherishing the child's inner world and reality as much as that she experiences outside of herself. Rather than be cruel or victimizing, crediting children, even in the worst of circumstances, with responsibility over their own lives and the choices they make is ultimately more respectful, freeing, empowering, and therapeutic. Neither the child who must do what is asked of him nor the one who never can oblige is truly free. Psychoanalytic therapy works to help children learn what it is they think is the right, good, or satisfying thing to do.

No less than adults who drink, abuse, or otherwise deny their problems, child patients cannot make changes in their lives until they admit what is happening. Our steady and empathic ears and eyes gradually invite the child to tell it like it is, to confess that they do lie, steal, act mean, try to irritate their parents, and so on. Once they can accept what they really do, and see the role it plays in their troubles, children can make decisions as to what, if anything, they wish to do about it. No one, not even a preschooler, will change until he has insight into his difficulties, until he wishes to do something to make it better, and sees a reason for doing so.

But acknowledging reality can be hard. Child-centered therapists, such as the gifted play therapist and theorist Virginia Axline (1981) believe that with enough unconditional love and acceptance, the child will, like a flower, increasingly unfold until fully revealed and bloomed in all his or her rich potential.



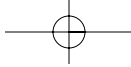
Many children, like adults, often cannot broach the matters that most pain and shame them, no matter how accepting we clinicians are. We as therapists often have to confront our child patients, “interpreting” or pointing out what they are not quite aware of or noting a discrepancy between what they say (and wish to believe) and what is actually true. We sometimes need to spotlight important behaviors and words, especially discrepancies between them, that left to the child might go undetected and unanalyzed. “You cry about calling your mother a bitch, but you’re smiling all the while.” After all, while we try to follow the lead and pace of the child, we do wish to do as much as we therapeutically can as quickly as possible. (There is no virtue in any child suffering or living in compromise any longer than she has to.)

Everything the psychoanalytic play therapist does is in the service of the child’s self-discovery and his assuming more responsibility for his life. But just as we promote his increasing sense of ownership (of therapy and his life) so do we attend to other realities. Recognizing that children are in their parents’ keep, we work (see below) to guide, support, and awaken parents, always doing so with an eye to the child’s needs. While honoring our individual work with the child, we do not hesitate to meet with parents or family members—sometimes with, sometimes without the child herself—if it is clinically warranted. We keep abreast and involved with the school and educational issues and enlist the consultation of psychiatrists if we think that medication might offer benefits. Though we keep our work with the child in the spotlight—cherished, insulated, and nurtured—we never lose sight of the facts of the child’s life and the bigger world in which he spends most of his days and hours.

ROLE OF THE THERAPIST

In no mode of treatment is the role of the therapist more entwined with the basic theory and constructs. In many ways, the therapist and her way of being *is* the intervention. As with any relationship-based therapy, the therapist strives to create an atmosphere of safety and acceptance, of genuine positive regard for the child. Our empathic and inquisitive posture toward the child, her experience, and her self-expression are essential. We show respect for the child’s thoughts and feelings, for no other reason than they are the child’s own. If psychotherapy is, to a great degree, a self-inquiry, then we aim to create the conditions in which a child will be most willing to risk the pain and humiliation of looking in the mirror.

Being human we will, of course, have opinions and feelings about the child’s behaviors and choices. Hearing, for instance, that a child we are seeing tortures field mice will distress many of us. But reprimanding him will not likely do him



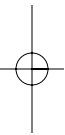
6 Psychoanalytic Play Therapy

or the mice any more good than has the yelling of the parents and teachers in the boy's life. We may share with him our sense that what he's doing is not good and that it suggests to us that he is not as happy and content as he appears to be. But we try to stay neutral, not to the boy, but to his conflict, so that he can openly explore what need his sadism serves. The old ideal of the analytic therapist as aloof and detached was a distortion of what was really needed. Children, even those within psychodynamic treatment, need therapists who, while able to manage their own psychic stuff, are emotionally genuine, available, and sincere.

The feelings that a child patient summons in us, sometimes called *counter-transference*, is valuable information. Sometimes, it says more about us and our own issues, issues that we need to clear up on our own time or at least keep out of the child's way. At other moments, what we feel—wanting, maybe, to hurt the boy who so hurts others, or conversely, wanting to buy a child special gifts—can help us understand what is going on in the child and the treatment. Many more times than not, we don't share the fantasies and feelings that a child evokes in us (though sometimes we do). Instead, we listen to what our own insides are telling us, helping us to avoid saying or doing something impulsive that hurts the child and derails the therapy.

The psychoanalytic play therapist, like every other kind of play therapist, as wisely laid out by the child-centered therapist, Haim Ginott (1959), sets limits so that the child cannot hurt himself, the therapist, or the office. Letting the child lose control in that way would frighten him, leaving him at the peril of his own uncontained aggressions and impulse. By setting limits on such behaviors, the therapist channels the child's impulses toward symbolic action. "No," we say, you can't hurt me, but here's a doll that can stand in for me and that you can do anything to." We don't permit our child patients to harm us, but they can freely abuse, molest, abandon, and even love, dolls or figures created to represent us (or others). By setting such limits, we maintain the child's sense of safety while broadening and deepening the space for self-expression.

Perhaps, more than anything, we show the child patience, respect, and honesty. If we don't have these to offer generously, what reason does the child have to offer them back or to trust us? We honor the child's own love of her father, even if he mistreats her. We don't pick on the child's nervous twitch, even if it unsettles us. We always first listen to her side of every story. And we shoot straight. In my experience, even very young children respond to candor when it is in their own best interest (and they are very good at telling if it is). Many naïve onlookers think that child therapists serve mostly as big buddies for the children who come to see them (not that good friends aren't worth a great deal). But we know better. These children come for professional help because they feel troubled, hurt, and maybe, even lost.



ROLE OF THE PARENTS

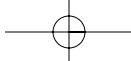
Bringing one's child to a therapist is not easy and can represent a most loving and courageous act. Admitting that your child is hurting or needs professional help is painful and can threaten your self-esteem as a parent. Even when parents bring a child to therapy because a school or some other agencies pushed for it, we should give them credit for doing so.

The more we can involve the parents in the treatment, the better the treatment works. We need the parents' cooperation to get the child to us, meeting after meeting, and to do the business of therapy (e.g., pay bills and copayments, present insurance or Medicaid cards, fill out forms). But there are several other reasons.

Parents are a primary source of information about the child and the home. Parents can tell us their perceptions of the child's behaviors at home, how he gets along with siblings or peers, and how he does in school. They can give us a history of the child's development as well as explain the reason for the referral. In dealing with parents, we strive to listen carefully and respectfully, so that the parents feel willing and trusting to speak candidly and fully. Parents will be guarded against revealing their uglier and darker parenting moments if they feel critiqued or looked down on. We strive to meet parents where they are, whatever their lifestyle. They come for our help and not our judgment.

We try to educate and inform parents about development, especially their child's. Although we don't betray the child's confidentiality, we work to translate the child's experiences, hurts, and needs into terms that parents can grasp and tend to. Telling them that Thomas is "narcissistically vulnerable" can be useless and off-putting. But explaining how easily he feels rejected, challenged, and unloved will make sense and touch them. We also educate, as when we show a mother how to better synchronize with her toddler or we describe why a stepfather might move more slowly with his rejecting stepson. Because the child is still in the middle of her childhood and its influence, we wish to guide parents in the right directions even as we help the child to understand and cope with what's already happened or what continues to be true in his home and life.

We never forget that the child-therapist relationship, however powerful, runs second to the relationship the child has with the parent. We need parents not only to support the child's coming to therapy, but to support the changes she needs or is herself making. Parents can be our greatest allies or saboteurs. For example, we will need to explain why Heather's fresh backtalk is actually a step forward on her way to managing her physical aggression. I often explain to parents that by working hard to better understand and deal with their child, they will hasten the progress and rewards of treatment. The prospect of saving time and money (on treatment) can be a strong incentive for parents.



8 Psychoanalytic Play Therapy

While the child therapist empathizes with the parents' difficulties parenting a particular child, he doesn't ignore parental irresponsibility, failures, or shortcomings. If parents act or speak in ways that thwart their child's growth or that somehow sidetrack his developing, they need (and deep down want) to know. I have found that when I speak with compassion and candor, parents are willing to hear the truth, even if it is painful. We also try to offer some concrete guidance at the same time so that parents do not feel overwhelmingly discouraged.

Every course of therapy has its share of bumps and setbacks. By working to form strong connections with our young patients' parents, we help to ensure good feeling and positive leverage to help keep us going in the inevitable times of trouble, crisis, and doubt.

Case Illustration

Wendy was referred to me, when she was 8-years-old, because of debilitating anxiety and school phobia. School absence had become an urgent problem. Wendy frequently stayed home or left school early with a stomachache, frequently accompanied by nausea, vomiting, and fever. In spite of her somatic distress, her pediatrician and several specialists in Boston found her to be in good physical health. Wendy's parents described her as isolated, withdrawn, and irritable. She clung to her mother and, though invited by classmates, would never accept a play date outside of her home. Teachers noted her inhibited and joyless demeanor. Her work and involvement, they judged, was far below what she was capable of. In short, Wendy was a very unhappy child living an increasingly inhibited life.

Wendy's anxiety and predicament were both quickly apparent in our work together. Wendy sat stiffly and without expression, occasionally smiling nervously as if to keep me at bay. She wouldn't allow her mother to leave my office for the first several meetings, panicking whenever her mother made a move toward the door. Wendy acknowledged often feeling sick to her stomach, not wanting to go to school anymore, and, with tears and difficulty, wanting "to do anything to feel better." When I made suggestions, however, of things to try, Wendy made it clear that she had no wish to hear them, saying explicitly that she might prefer keeping things as they were. I let Wendy know that I thought I could be of help, that I thought the therapy would be painful and hard, and that, it would take some time. I encouraged her mother to keep her in school, to keep in mind that she was healthy, and to make sure that she gets to therapy even, as I predicted, when she feels she cannot come.

In the first months, Wendy came to therapy willingly, if with minimal engagement, and allowed her mom to wait in the adjacent room. Our work consisted mostly of Wendy's drawing pictures of happy-go-lucky children romping

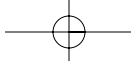
on beaches and smiling suns drenching colorful fields of smiling trees and smiling butterflies. Her pictures were as rigidly happy as she, in person, was rigidly tense and miserable. She answered questions with almost inaudible one-word replies that quietly felt enraged and purposeful. When we addressed her stomach aches, she'd grow teary, helpless, and shake visibly. "You hate feeling so sick," I'd say. "Yes," she'd sadly confirm. Hour after hour I'd ask her gently to show me where it hurt, and to tell me in detail about all the uncomfortable sensations she got in her belly. Telling me about this gas pain and that lump in her chest brought her visibly to life, and evoked an energy, good cheer, and break from the tension that tormented her. As soon as our talk returned to the dilemmas in her life, however, she immediately closed down and turned sullen.

In spite of her reluctance to directly discuss her school avoidance, by the end of the second month, Wendy was going to school more easily and had stopped going to the nurse's office. "She doesn't believe I'm really sick," Wendy complained to me, her first use of me as a confidante. When I reminded Wendy that it was me who'd suggested that the school nurse no longer indulge her, and asked if she might be mad at me, Wendy made clear that I'd done the right thing, confirming that she really did want my help and knew what was needed.

Gradually, over a period of several months, Wendy grew more connected with me. She spent less time talking about her body, and, in fact, was having many fewer belly aches. She instead complained about what transpired outside of her body. Wendy described a teacher who "always called on other children," a classmate who thought she was better than everyone else, and another girl in dance class who hogged the instructor's attention. When talking about these incidents, Wendy again came to life, revealing palpable envy and resentment. "It's not fair," I'd say. "You want them to notice how special *you* are." My words would evoke Wendy's silence, sad nod, and reddened eyes.

The more fully that Wendy lamented in therapy about the ways in which other children seemed to get more attention, and the more overtly miserable she appeared in treatment, the more glowing were the reports I'd get from her mother. Her grades were up and she was going to school easily. She was growing enthused about her teachers, projects, and after-school activities, and she was making friends. She, to my amazement, successfully auditioned for a community play and volunteered for two dance recitals. Admitting her anger at children who were more able to enjoy the limelight and growing aware of her own needs to be noticed and admired, allowed Wendy to start pursuing, attaining, enjoying center stage in a way she previously could only yearn for secretly and bitterly.

But everything wasn't rosy. While her life outside therapy and home was growing more robust, she was becoming a tyrant at home. Wendy browbeat her



10 Psychoanalytic Play Therapy

parents, especially her mother, criticizing everything they did. She also incessantly put her younger sister down, calling her “dumb” and saying exactly what she knew would hurt the most. Wendy’s never-before-seen mean streak put her parents in a quandary. They disliked her mistreatment of the family, and yet rejoiced the otherwise happy, involved, and well-liked child that Wendy was becoming. With my support, they accepted Wendy’s behavior as a necessary phase and let her and her treatment be.

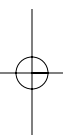
Wendy’s psyche had other plans. Just as her progress was zooming—school issues had all but vanished; she performed as a dancer and actress comfortably and admirably; she was able to play at friend’s homes and attend birthday parties—Wendy’s treatment hit a therapeutic wall.

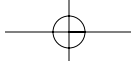
During one session, Wendy felt so nauseous that she spent it silently curled in a chair. The next week the nausea—which had disappeared the second she’d left my office—came back acutely right before she came to her appointment; again, she “slept” the hour away, rejecting any attempt of mine to query or intervene. For weeks, this pattern quickened, each week the nausea coming more intensely and earlier in the day of her meeting with me, until culminating in a dramatic panic.

I heard the ruckus before getting to the waiting room. Wendy lay on the floor and wildly kicked the air as if fighting off invisible monsters. “I can’t,” she yelled. “I can’t.” Wendy got angrier. When her mother tried to get her up and into my office, Wendy’s upset escalated. *I hate you’s* deteriorated to primitive grunts and dry heaving. Her arms and body trembled. Seeing that nothing her mother and I did could console her, I quietly sat down beside Wendy. Her mother followed. We spent the remaining time in silence, Wendy finally sobbing and sobbing on her mother’s lap until leaving in her mother’s embrace.

“I don’t know what happened,” her mother called the next day to tell me in appreciative disbelief. “Since we left your office, she’s been the happiest I’ve ever seen her. It’s like the weight of the world fell off her shoulders.” Sometimes parents can describe it better than any fancy psychobabble or theory can.

For many weeks afterward, Wendy and I piece-by-piece discovered exactly what had happened. Wendy feared coming to therapy because of what she was feeling. She’d been having awful thoughts about her younger sister whom she loved dearly. “I get so jealous of her. Sometimes I wish she wasn’t here,” Wendy said with shame and great sadness, hearing the murderous rage not-so-hidden in her words. We learned that a number of family visitors over the previous weeks had made a great fuss over Wendy’s sister, a sweet, bright, and adorable child. “Why can’t I stay little?” Wendy asked in earnest. “Why do I have to grow up?”





Wendy's impressive maturing over the past months scared her. While she enjoyed the positive attention it was bringing her, she'd noticed something else. "The better I do," she said, "the less everyone thinks I need." Wendy wondered if maybe being "sick" wasn't better. But she knew herself. "I have to grow up, don't I?" she asked, hanging her head, answering her own question.

Growing up is a painful enterprise. Wendy had tenaciously hung onto childhood, hoping she could hold off what nature demands. Therapy allowed her to grieve all that she imagined growing up would cost her, making room for her to live a more mature and full life, a life that was, to her surprise, bringing her a satisfaction, pride, and joy that she'd never imagined possible.

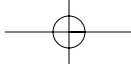
CLINICAL APPLICATIONS

While psychoanalytic principles of child development can inform our work with most any child, even if short term or in another primary modality, psychoanalytic play therapy seems to hold most value for certain types of problems. It is especially good at helping children with anxiety, depression, those with borderline and psychotic functioning, and those who need to reconcile themselves to limitations, such as chronic illness or learning disabilities. Psychodynamic therapy, though taking time, can help disconnected children attach to themselves and their families. It, as I stressed earlier, also is quite adept at lessening self-hatred and problematic narcissism, tenacious issues by any clinician's standards.

It may not be the best first choice, however, for children who seek quick relief for a specific phobia or help managing a single life event. This kind of talk-and-insight therapy is not well suited for children who lack consciences, who feel no remorse, and who have utterly no interest in looking at themselves. Likewise, psychoanalytic therapy may not only help but can make worse children who are alcoholic or addicted to drugs. Other approaches, such as family therapy, may better help children whose problems reside mostly in parent or family strife.

EMPIRICAL SUPPORT

Just as is true for its ancestors, psychoanalysis and psychodynamic psychotherapy, the empirical study of psychoanalytic play therapy has been sparse and weak. The vast majority of research has been in the form of the case study, the in-depth and subjective analysis of a single child's treatment. For many decades, *The Psychoanalytic Study of the Child*—an annual volume published originally by the International University Press and now, Yale University Press—has presented many



12 Psychoanalytic Play Therapy

such studies as well as theoretical essays by the world's foremost analytic clinicians. The much younger *Psychoanalytic Psychology* also occasionally publishes detailed reports of individual child treatment. These writings have often been exceptional in their observations and insights. But they do not equal experimental and controlled findings.

The reasons for the paucity of research are many. Foremost, the kind of clinicians who are attracted to such an in-depth, detailed, rich, complicated form of treatment are less likely to be interested and skilled in research. Second, the methods of psychoanalytic play therapy (e.g., interpretations, empathic listening) cannot be standardized the way that a behavioral intervention or cognitive-behavioral strategy can be. Third, many of the goals and experiences of psychoanalytic therapy—ego growth, self-awareness, comfort within one's own skin—again are not that easy to define and assess quantitatively. Fourth, psychoanalytic therapy is as much art as science. On the surface, three child therapists can say and do everything identically and yet have very different effects on the child.

This can all sound like a cop out, too easily surrendering to the belief that psychoanalytic child therapy can neither be proven nor scrutinized. Researchers and clinicians of other perspectives often see it as such. Good research is ever welcome, even though I am doubtful that the psychoanalytic method will ever prove its worth and mechanism to satisfy empirical science. As you will soon read in this book, some of the more behavioral and structured approaches to child therapy are far ahead in terms of outcome research. Much of what convinces you about theory and practice will come, however, as much from your experience with real children as it does from academic journals. The child therapist's obligation is to learn from every source available.

CONCLUSION

Psychoanalytically-informed play therapy can be a powerful form of treatment. But it can sometimes be lengthy, costly, hard, and painful for both children and their parents. For the child therapist, learning and mastering psychoanalytic play therapy can be demanding, both intellectually and emotionally. It requires conviction and personal involvement. (But what worthwhile things in life come easy?) That said, the psychodynamic perspective's appreciation for the child's inner and outer world, her ways of managing her life and experience, and its spotlighting her relationship with the therapist, make it a rich and intriguing intervention. By evolving to integrate the findings of educators, behaviorists, developmental research, neurology, family systems therapists, and biological psychiatry, this approach has only grown stronger, more flexible, and more adaptable to the needs and realities of children and families.

REFERENCES

- Axline, V. (1981). *Play therapy*. New York: Ballantine Books.
- Freud, A. (1974). The methods of child analysis. In *The Writings of Anna Freud*. New York: International Universities Press. (Originally published 1927)
- Freud, S. (1905). Three essays on the theory of sexuality. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 7, pp. 123–230). London: Hogarth Press.
- Freud, S. (1955). Analysis of a phobia in a five-year-old boy. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 10, pp. 1–147). London: Hogarth Press. (Original work published 1909)
- Ginott, H. (1959). The theory and practice of therapeutic intervention in child treatment. *Journal of Consulting Psychology*, 23(2), 160–166.
- Hug-Hellmuth, Hermine von. (1920). On the technique of child-analysis. *International Journal of Psycho-Analysis*, 2, 287–305.
- Irwin, E. (1983). The diagnostic and therapeutic use of pretend play. In *Handbook of play therapy*. New York: Wiley.
- Jacobson, E. (1954). The self and object world. *Psychoanalytic Study of the Child*, 9, 75–127.
- Klein, M. (1975). *The psycho-analysis of children*. New York: Delacorte. (Original work published 1932)
- Kohut, H. (1971). *The analysis of the self*. New York: International Universities Press.
- Winnicott, D. (1975). Primitive emotional development. In *Through pediatrics to psycho-analysis*. New York: Basic Books. (Original work published 1945)