UNIT 4 METHODS OF CHILD PSYCHOTHERAPY

Structure

4.0 INTRODUCTION

Mental health interventions for children vary with respect to the problem being addressed and to the age and other individual characteristics of the child. Although such interventions share some approaches, treatment methods can be quite different from each other. Terms describing child treatments may vary from one part of the world to another, with particular differences in the use of the terms "psychotherapy" and "psychoanalysis". This unit will cover all types of therapies aimed at children and include behavioural, psychodynamic and other therapies.

4.1 OBJECTIVES

After completing this unit, you will be able to:

- Describe the different types of treatment methods employed in child psychotherapy from different theoretical fields;
- Discuss the principles and concepts behind treatment interventions; and
- Understand the techniques employed in different child psychotherapy interventions.

4.2 PSYCHOANALYTIC APPROACHES

There are several different techniques to approach the psychoanalytic treatment of children. For children at a very young age an adapted psychoanalytic technique

might be necessary. In some cases parent-infant psychotherapy is also used. We would be discussing two types of techniques: Parent-Infant Psychotherapy and Mentaliseren Bevorderende Kinder Therapie (MBKT). Parent-Infant Psychotherapy addresses problems with normal relationships between parent and child. MBKT addresses problems with an infant's ability to distinguish reality and fantasy.

4.2.1 Parent Infant Psychotherapy

If the normal course of secure attachment between parent and infant is disrupted, parent infant psychotherapy is one technique that can be used to restore this bond. This technique requires a three way relationship between the parent, child and therapist. During the therapy sessions the parent expresses his or her thoughts and feelings which are based on a combination of factors including:

- The parent's experiences as a child.
- The parent's expectations and hopes for the child's future.
- The relationships the parent has with other people.

The therapist's role is as an observer and an interpreter of the interaction between the child and the parent.

The therapist might share some of his thoughts about the behaviour of the child with the parent and by doing so offering the parent an alternative way of experiencing the child. This technique helps the parent to resolve issues with his or her own infancy-experiences in order to restore secure attachment with the infant. And it helps lower the risk for psychopathological developments of the child in the future.

4.2.2 Mentaliseren Bevorderende Kinder Therapy (MBKT)

Since 2003, The Nederlands Psychoanalytisch Instituut NPI (Dutch Psychoanalytic Institute) has been working with a form of therapy for children called "*Mentaliseren Bevorderende Kinder Therapie*" (MBKT) which can be roughly translated as "*therapy for children enhancing their ability to mentalise*".

This therapy is partly based on the theory of Fonagy (2002) in which mentalisation is the central theme. Mentalising is accomplished when two developmental concepts i.e., the equivalent modus and the pretend modus can be integrated.

A child that functions according to the equivalent modus only, does not experience a difference between reality and fantasy. Inside and outside are equal. With a child that only functions in the pretend modus there is a difference between reality and fantasy. However they exist separately from each other. The child is not aware of the reality level when he is pretending. When both modus are integrated the child is aware that he is pretending and then mentalisation gets established.

Mentalisation is a conscious as well as an unconscious process which enables people to see that actions and thoughts of themselves and others are motivated by internal thoughts, intentions and attitudes.

A child's development of self regulating mechanisms and ability to mentalise (which, when taken together are called Interpersonal Interpretative Function, IIF) are dependent on their "early attachment relation".

Trauma can cause the child to detach from very painful feelings connected to the events and or persons connected to the trauma. This incapability to integrate those feelings may influence the modus in which the child comes to operate.

An overwhelming flow of anxiety for instance can cause the child to fall back in to an equivalent modus of operating.

Other components which are crucial in the development of the child and also mainly dependent on the quality of the attachment to the parent are "attention regulation" and "affect regulation".

When the regulation of either is not sufficient a therapy may help to influence the flow of both.

The starting point in "*attention regulation*" is that the child is still functioning from the "*equivalent modus*" which means there are insufficient affect representations.

Here the main goal is to direct and focus the attention of the child to the inner world (feelings, thoughts, wishes and impulses). This focuses their mental being more on physical reality.

In *affect regulation* the often diffuse affects of the child within the therapeutic relation are explored. Here it is important that the child goes through their own feelings and recognise them by forming them into mental representations. As this '*mentalisation process*' develops the child functions in the pretend modus and is capable of using symbolic representations. Interventions are based on improving thinking about mental conditions and mental processes.

MBKT can be qualified as an intensive form of therapy with two to five sessions per week. These sessions are a combination of talk and play. The therapist will play and talk with the child in order to make contact with the inner world of the child and thus shape all the bits and pieces that needs to be integrated. An important tool is the transference/ counter transference. These can lead the way to what needs to be treated.

4.3 ATTACHMENT BASED INTERVENTIONS

Although attachment theory has become a major scientific theory of socio emotional development with one of the broadest, deepest research lines in modern psychology, attachment theory has, until recently, been less clinically applied than theories with far less empirical support. This may be partly due to lack of attention paid to clinical application by Bowlby himself and partly due to broader meanings of the word 'attachment' used amongst practitioners. It may also be partly due to the mistaken association of attachment theory with attachment therapy, also known as 'holding therapy', a group of unvalidated therapies characterised by forced restraint of children in order to make them relive attachment related anxieties; a practice considered incompatible with attachment theory and its emphasis on 'secure base'. The approaches mentioned below are examples of recent clinical applications of attachment theory by mainstream attachment theorists and clinicians and are aimed at infants or children who have developed or are at risk of developing less desirable, insecure attachment styles or an attachment disorder.

4.3.1 Dyadic Developmental Psychotherapy

Dyadic developmental psychotherapy is an evidence-based treatment approach for the treatment of attachment disorder, Complex Post Traumatic Stress Disorder, and reactive attachment disorder. It was originally developed by psychologist Dr. Daniel Hughes, as an intervention for children whose emotional distress resulted from earlier separation from familiar caregivers. Hughes developed Dyadic developmental psychotherapy with the express intention of developing a therapy removed from the coercive practices of attachment therapy. Hughes cites attachment theory and particularly the work of John Bowlby as the theoretical basis for dyadic developmental psychotherapy. Other sources for this approach include the work of Stern, who referred to the attunement of parents to infants' communication of emotion and needs, and of Tronick, who discussed the process of communicative mismatch and repair, in which parent and infant make repeated efforts until communication is successful. Children who have experienced pervasive and extensive trauma, neglect, loss, and/or other dysregulating experiences may benefit from this treatment.

The basic principles of Dyadic Developmental Psychotherapy are:

1) Safety
2) Self-regulation
3) Self-reflective information processing
4) Traumatic experiences integration
5) Relational engagement and
6) Positive affect enhancement

Dyadic developmental therapy principally involves creating a "playful, accepting, curious, and empathic" environment in which the therapist attunes to the child's "subjective experiences" and reflects this back to the child by means of eye contact, facial expressions, gestures and movements, voice tone, timing and touch, "co-regulates" emotional affect and "co-constructs" an alternative autobiographical narrative with the child. Dyadic developmental psychotherapy also makes use of cognitive behavioural strategies.

4.3.2 'Circle of Security'

This is a parent education and psychotherapy intervention developed by Marvin et al (2002) which is designed to shift problematic or 'at risk' patterns of attachment-caregiving interactions to a more appropriate developmental pathway. It is based on contemporary attachment and congruent developmental theories. Its core constructs are Ainsworth's ideas of a Secure Base and a Haven of Safety (Ainsworth et al 1978). The aim is to present these ideas to the parents in a 'user friendly', common-sense fashion that they can understand both cognitively and emotionally. This is done by a graphic representation of the child's needs and attachment system in circle form, summarising the child's needs and the safe haven provided by the caregiver. The protocol has so far been aimed at and tested on preschoolers up to the age of 4 years.

The aim of the therapy is:

- To increase the caregivers sensitivity and appropriate responsiveness to the child's signals relevant to his/her moving away from parents to explore, and moving back for comfort and soothing;

- To increase their ability to reflect on their own and the child's behaviour, thoughts and feelings regarding their attachment-caregiving interactions; and
- To reflect on experiences in their own histories that affects their current caregiving patterns. This latter point aims to address the miscuing defensive strategies of the caregiver.

Its four core principles are that the quality of the child parent attachment plays a significant role in the life trajectory of the child, that lasting change results from parents changing their caregiving patterns rather than by learning techniques to manage their child's behaviours, that parents relationship capacities are best enhanced if they themselves are operating within a secure base relationship and that interventions designed to enhance the quality of child-parent attachments will be especially effective if they are focussed on the caregiver and based on the strengths and difficulties of each caregiver/child dyad.

There is an initial assessment which utilises the 'Strange Situation' procedure, (Ainsworth 1978), observations, a videotaped interview using the Parent Development Interview (Aber et al 1985) and the Adult Attachment Interview (George et al 1984) and caregiver questionnaires regarding the child. The child's attachment pattern is classified using either Ainsworth or the PAC (Preschool Attachment Classification System).

The therapy is then 'individualised' according to each dyads attachment/caregiver pattern. The programme, which takes place weekly over 20 weeks, consists of group sessions, video feedback vignettes and psycho educational and therapeutic discussions. Caregivers learn, understand and then practice observational and inferential skills regarding their children's attachment behaviours and their own caregiving responses.

Circle of Security is being field tested within the 'Head Start/ Early Head Start' programme in the USA. According to the developers the goal of the project is to develop a theory and evidence based intervention protocol that can be used in a partnership between professionals trained in scientifically based attachment procedures, and appropriately trained community based practitioners.

It is reported that preliminary results of data analysis of 75 dyads suggest a significant shift from disordered to ordered patterns, and increases in classifications of secure attachment.

4.3.3 Attachment and Biobehavioural Catch-Up (ABC)

This is an intervention programme aimed at infants who have experienced early adverse care and disruptions in care. It aims to provide specialised help for foster carers in recognition of the fact that a young child placed in foster care has to deal with the loss of attachment figures at a time when maintaining contact with attachment figures is vital. It targets key issues: providing nurturance for infants when the carers are not comfortable providing nurturance, overriding tendencies to respond in kind to infant behaviours and providing a predictable interpersonal environment.

It is essentially a training programme for surrogate caregivers. It has four main components based on four propositions:

"Providing nurturance when it does not come naturally".

Based on findings that foster children's attachments are disproportionately likely to be disorganised.

As foster mothers with an unresolved or dismissing state of mind are likely to have children with disorganised attachments, the interpretation of Dozier et al is that foster children have difficulty organising their attachment systems unless they have nurturing foster carers.

The goal is to help foster parents provide nurturing care even if they are non autonomous with regard to their own attachment status.

"Infants in foster care often fail to elicit nurturance". Foster carers tend to respond 'in kind' to infants behaviour. If foster infants behave in an avoidant or resistant manner, foster carers may act as if the infant does not need them. The goal is to train foster carers to act in a nurturing manner even in the absence of cues from the infant.

"Infants in foster care are often dysregulated at physiological, behavioural and emotional levels". Foster children often show an atypical production of the stress hormone cortisol. It is not established whether this is significant for increased risk for later disorders, but very low or very high levels are associated with some types of psychopathology in adults. The goal here is to help foster parents follow the child's lead and become more responsive social partners.

"Infants in foster care often experience threatening conditions". One of the functions of parents is to protect children from real or perceived dangers. This has often broken down for foster children, and worse, the caregiver may have served as a threat themselves. Prime examples are threats contingent upon behaviour to have the child removed or taken away.

Children experiencing frightening conditions have a limited range of responses and often 'dissociate' as a way of coping. The aim is to reduce threatening behaviour among foster parents by helping them understand the impact on the child.

Caregiver and child behaviours are assessed before and after intervention, as is the child's regulation of neuroendocrine function. The intervention consists of 10 sessions administered in caregiver's homes by professional social workers. Sessions are videotaped for feedback and for fidelity.

The intervention is currently being assessed in a randomised clinical trial involving 200 foster families, supported by the National Institute of Mental Health. Half the infants are assigned to the Developmental Education for Families programme as a comparison intervention. The developers themselves point out that they do not test for caregiver commitment although they state this may or may not be a critical omission as they consider caregiver commitment to be a crucial variable in terms of child outcomes.

4.4 PLAY THERAPY

Play therapy can be defined as a means of creating intense relationship experiences between therapists and children or young people, in which play is the principal medium of communication. Play therapy refers to a method of psychotherapy

with children in which a therapist uses a child's fantasies and the symbolic meanings of his or her play as a medium for understanding and communication with the child.

The aim of play therapy is to decrease those behavioural and emotional difficulties that interfere significantly with a child's normal functioning. Inherent in this aim is improved communication and understanding between the child and his parents. Less obvious goals include improved verbal expression, ability for self-observation, improved impulse control, more adaptive ways of coping with anxiety and frustration, and improved capacity to trust and to relate to others. In this type of treatment, the therapist uses an understanding of cognitive development and of the different stages of emotional development as well as the conflicts common to these stages when treating the child.

Play therapy is used to treat problems that are interfering with the child's normal development. Such difficulties would be extreme in degree and have been occurring for many months without resolution. Reasons for treatment include, but are not limited to, temper tantrums, aggressive behaviour, non-medical problems with bowel or bladder control, difficulties with sleeping or having nightmares, and experiencing worries or fears. This type of treatment is also used with children who have experienced sexual or physical abuse, neglect and the loss of a family.

Children communicate their thoughts and feelings through play more naturally than they do through verbal communication. As the child plays, the therapist begins to recognise themes and patterns or ways of using the materials that are important to the child. Over time, the clinician helps the child begin to make meaning out of the play.

At times, children in play therapy might also receive other types of treatment. For instance, youngsters who are unable to control their attention, impulses, tendency to react with violence, or who experience severe anxiety may take medication for these symptoms while participating in play therapy. The play therapy would address the child's psychological symptoms. Other situations of dual treatment include children with learning disorders. These youngsters may receive play therapy to alleviate feelings of low self-esteem, excessive worry, helplessness, and incompetency that are related to their learning problems and academic struggles. In addition, they should receive a special type of tutoring called cognitive remediation, which addresses the specific learning issues.

Treatment can be described as occurring in a series of initial, middle and final stages. The initial phase includes evaluation of the problem and teaching both child and parents about the process of therapy. The middle phase is the period in which the child has become familiar with the treatment process and comfortable with the therapist. The therapist is continuing to evaluate and learn about the child, but has a clearer sense of the youngster's issues and has developed, with the child, a means for the two to communicate. The final phase includes the process of ending treatment and saying goodbye to the therapist.

4.5 PARENT CHILD INTERACTION THERAPY (PCIT)

Parent child interaction therapy (PCIT) was first introduced in the 1970's and has been proven effective for abused and at risk children with disruptive behaviours at ages 2 ½ to 8 and their biological or foster caregivers. It uses a unique combination of behavioural therapy, play therapy and parent training to teach more effective discipline techniques and improve the parent child relationship. It is appropriate where parent child relations have broken down, where parent child interaction is poor or where parent child communication is problematic.

Therapists coach parents while they interact with their children during PCIT, by sitting behind a one way mirror and using an "ear bug" audio device to guide parents through strategies that reinforce their children's positive behaviour. The live coaching and treatment of both parent and child together are cornerstones of this approach. PCIT is divided into two stages: relationship development (Child Directed Interaction) and discipline training (Parent Directed Interaction).

The Child Directed Interaction portion of PCIT aims to develop a loving and nurturing bond between the parent and child through a form of play therapy. Parents are taught a list of "Dos" and "Don'ts" to use while interacting with their child. They are asked to use these skills during a daily play period called Special Play Time.

Parents are taught an acronym of skills to use during Special Play Time with their children. This acronym varies from therapist to therapist, but is generally either "*DRIP*" or "*PRIDE.*"

DRIP stands for the following:

D - Describe

R - Reflect

I - Imitate

P - Praise

Likewise, **PRIDE** stands for the following:

P - Praise

R - Reflect

I - Imitate

D - Describe

E - Enthusiasm

These acronyms are reminders that parents should describe the actions of their child, reflect upon what their child says, imitate the play of their child, praise their child's positive actions, and remain enthusiastic throughout Special Play Time.

Phase II, or Parent Directed Interaction, focuses on establishing a structured and consistent approach to discipline; parents are coached during a play situation by

the therapist to use skills in giving clear direct commands, and provide consistent consequences for both compliance and noncompliance.

PCIT reduces behaviour problems in young children by addressing negative parent-child patterns and teaching parents how to model and reinforce constructive ways to manage emotions. PCIT decreases the risk of child physical abuse by interrupting the harmful cycle that can be present between the parent and child, where the parent's negative behaviours such as screaming or threatening, reinforce negative behaviours of the child such as unresponsiveness and disobedience. The model encourages positive interaction, and implementation of consistent and nonviolent discipline techniques. Parent satisfaction with PCIT is typically high. Additionally, the model offers support for caregivers and can be adapted for use with various populations and cultures.

4.6 THE DEVELOPMENTAL, INDIVIDUAL DIFFERENCE AND RELATIONSHIP BASED MODEL (DIR)

The Developmental, Individual Difference, Relationship Based model (DIR) summarises an approach that builds on growing insights regarding functional developmental capacities, biologically based processing differences, and emotionally meaningful learning interactions between families, caregivers, and children.

The "D" stands for functional Developmental levels; i.e., seeing where the child is in her development.

"I" stands for Individual differences in processing; the processing profile in terms of auditory processing, visual/spatial, sensory modulation, motor planning.

"R", stands for what the Relationships are like.

What are the interactive relationships and use of affects in the family now and what would be the ideal pattern to support enhanced development. ?

The DIR model looks comprehensively at the child and is an advance over the older ways of thinking, because the focus is not just on isolated cognitive skills and on surface behaviours but also on an integrated understanding of human development.

The integrated model of development includes interaction with caregivers and the environment, biologically mediated motor and sensory processing differences, and the child's functional developmental road map, i.e., determining where the child is in terms of the six functional developmental elements, that is

- attention,
- engagement,
- purposeful emotional signalling and gesturing,
- preverbal and verbal problem-solving and
- imaginative interactions,
- thinking, etc.).

These changes the way therapists do assessments and the way they plan interventions.

The DIR model, therefore, serves as a framework to understand the developmental profile of an infant or child and his or her family. It enables caregivers, educators, and clinicians to plan an assessment and intervention program that is tailored to the child's and family's profile. It is not an intervention, but a method of analysis and understanding that helps to organise the many intervention components into a comprehensive program.

DIR based comprehensive program includes semi-structured problem-solving, learning interactions, speech therapy, occupational therapy, peer play opportunities, educational programs, etc.

The DIR model is the most comprehensive conceptual framework available to understand and organise programs of assessment and intervention for children with special needs. It has helped many children with special needs, including autistic spectrum disorders, learn to relate to adults and peers with warmth and intimacy, communicate meaningfully with emotional gestures and words, and think with a high level of abstract reasoning and empathy.

Self Assessment Questions

1) Define the term 'mentalise'?

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2) What are the principles of Dyadic Developmental Psychotherapy?

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3) What are the aims of play therapy?

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4) What is the aim of Child-Directed Interaction phase of PCIT?

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5) What is the goal of Developmental, Individual-Difference, Relationship-Based model?

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4.7 LET US SUM UP

Psychotherapies for children vary with respect to the problem being addressed and to the age and other individual characteristics of the child. There are different types of therapies aimed at children from behavioural, psychodynamic or other fields.

There are several different techniques in the psychoanalytic treatment of children. In this unit we had discussed two types of techniques: Parent-Infant Psychotherapy and Mentaliseren Bevorderende Kinder Therapie (MBKT). Parent-Infant Psychotherapy addresses problems with normal relationships between parent and child. MBKT addresses problems with an infant's ability to distinguish reality and fantasy. Attachment based interventions are aimed at infants or children who have developed or are at risk of developing less desirable, insecure attachment styles or an attachment disorder. Dyadic developmental psychotherapy is designed to help parents understand their child's attachment disorder: how the child feels and thinks, and the child's internal psychological dynamics. Second, teaching parents about attachment facilitating parenting methods and the importance of attunement and responsive, sensitive parenting is essential in this therapy. 'Circle of security' is a parent education and psychotherapy intervention designed to shift problematic or 'at risk' patterns of attachment-caregiving interactions to a more appropriate developmental pathway. Attachment and Biobehavioural Catch-Up (ABC) is an intervention programme aimed at infants who have experienced early adverse care and disruptions in care. It aims to provide specialised help for foster carers in recognition of the fact that a young child placed in foster care has to deal with the loss of attachment figures at a time when maintaining contact with attachment figures is vital.

Play therapy refers to a method of psychotherapy with children in which a therapist uses a child's fantasies and the symbolic meanings of his or her play as a medium for understanding and communication with the child. Parent child interaction

therapy (PCIT) has proved to be effective for abused and at-risk children with disruptive behaviours at ages 2 ½ to 8 and their biological or foster caregivers. It teaches more effective discipline techniques and improves the parent-child relationship. It is appropriate where parent child relations have broken down, where parent child interaction is poor or where parent child communication is problematic.

The DIR model serves as a framework to understand the developmental profile of an infant or child and his or her family. It enables caregivers, educators, and clinicians to plan an assessment and intervention program that is tailored to the child's and family's profile.

4.8 UNIT END QUESTIONS

1) Discuss the psychoanalytical intervention methods for children?
2) Discuss in detail the different attachment based interventions?
3) Write about play therapy?
4) Describe the process of parent child interaction therapy?
5) Discuss DIR model?

4.9 SUGGESTED READINGS

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