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Family Process

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In Defense of Child Therapy

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Traditional child dyadic psychotherapy can be viewed from a family systems point of view. Seen in this light it shows itself to have powerful family systems effects. These are often therapeutically effective, although unintended. The deliberate identification of the child as "sick" and the choice of an intervention format that avoids direct dealing with the rest of the family may make change possible where it might otherwise not have occurred. Child psychotherapy is shown to have important elements in common with recently developed symptom oriented treatment methods.

In their enthusiasm for a new orientation of therapy, many family therapists disregard therapeutic approaches that have a long and respectable history. As family therapy expands and new approaches proliferate, many beginning family therapists seem to argue that if the whole family is not in the room, the therapy is old-fashioned. They disregard any therapy in which only individuals are interviewed. In doing so, they may overlook the valuable contributions made by earlier

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when he appears to be. A number of important factors are part of the total encounter that occurs in child therapy. To begin with, there is the situation that precipitates the child into treatment. A child must express a family problem in such a way that a limit of tolerance is passed and the family is driven to take action. Either the parents decide upon treatment because of internal stress in the family or because of their concern about a traumatic experience of the child, or they are pressured into such action by school authorities, the family physician, or friends and neighbors. Often, when the parents decide to follow through on a referral for their child, they confront each other with the seriousness of the problem for the first time. This in itself can be therapeutic, since the parents are mutually agreeing that something must be done and so readying themselves for a change. They must also tell the child that they are going to take him to a doctor. When the child realizes that this time it is not merely one of the previous ineffectual threats, he can begin to initiate new behavior. Usually the parents benevolently reassure the child about the nice qualities of the therapist, but he is aware of his parents' concern and anger with him.

The parents make an appointment with the child therapist who arranges to see the child and also to see the parents to set the fee and agree to the contract for treatment. During the interview with the parents, he listens to their complaints about the child, and when he agrees the child is disturbed, he offers treatment. Sometimes he must deal with the parental conflict over treatment, if one or the other parent has arranged it against the opposition of the other. Although these "management" aspects of the case are not usually considered theoretically to be central to the treatment, they are obviously crucial issues. Under the rubric of "management," there exists a range of effective techniques for making an impact upon the family system.

The Effects of Focusing on the Child

One major effect on the family occurs when the child therapist simply agrees with the parents that the child is the problem; this major intervention into the family joins the parents against their problem child. Since the theory of child psychopathology suggests that the child is reacting to his past and to his introjects, the therapists' approach to the parents can be one that frees them from the blame for the child's current problem. Granted that the child therapist is often

accused of condemning parents because he identifies with the child, he is still sufficiently guided by his theory to think of the current parental influence as less relevant than the "real" internalized problem of the child.

Some family therapists would argue that focusing on the child as the problem and, therefore, siding with the parents against the child would be disastrous for a good treatment outcome; they believe it is always unwise to join any family members against the others. In fact, family therapists argue that focusing upon the child in this way freezes the child in the pathological system so that change is not possible. However, experienced family therapists also recognize that family therapy is an orientation to a problem and not a method of treatment so that different approaches sometimes have different advantages.

Spontaneous Change

One advantage of the child therapist's approach to families is the "spontaneous" change that can happen. Although parents offer up a child as the problem and claim that all is well with the family, they know on another level that this is not so. In those cases in which the therapist agrees that the child is the problem, the parents must redress the balance by accepting some blame themselves. As an example, a child will not eat all his food but hides it in various places in the house. The child therapist who operates close to the basis of his theory circumvents parental resistance, as he assumes that this problem is related to the child's interiorized oral aggression and anal retention. He will imply to the parents that the problem is entirely within the child. However, the parents know that at the dinner table the father insists that the child eat everything on his plate and the mother insists he does not have to. To deal with this conflict, the child hides his food. Since the parents know they are participating in this situation, they must accept part of the blame themselves because the child therapist offers them none. Sensing from him an exonerating stance, they are indirectly freed to privately work on the conflict when they might not have done so if the therapist had taken an interest in it.

The parents can leave a first session with a child therapist reassured that the problem resides more within the child than in their parenting, and they can feel relieved that they have taken action to resolve their difficult problem. In some cases the child will immediately improve; it can be argued that this response occurs because so much has happened

within the family just by the action of reaching agreement, seeking treatment, and being reassured that they have not been causing the child's problems. Also, one should not underestimate the ability of the child to affect the other members of the family. The child can be a pivotal force for change when he senses his referral to a doctor as parental rejection. Upon feeling himself expelled, he can recoil into attempts to regain his parents' affection. His efforts may be interpreted by the parents as the therapist's success. They bring therapy to an end, and the child is rewarded by reintegration with his family.

The amount of time and effort the family puts into organizing themselves to get the child to the therapy sessions at regular intervals is in itself of importance. Not only is this a concerted activity requiring more efficient family organization, but often parents and child are thrown together for an extended period during the trip. Some parents report this is the only time during the week when they are engaged in a common activity with the child. The parents also experience themselves as being helpful and doing something for their child after living through long periods of feeling hopeless and powerless to help him.

Confidential Interviews With an Outsider

The family also faces the fact that the child is now going to an outsider, an expert, and revealing things about the family. Because of the confidentiality of the sessions, they cannot know what the child is reporting nor can they rebut what he might be saying. This concern about the child "revealing the family" can lead to more concerted effort by the parents to change the family so that what is reported will be more complimentary. Some families report that their most determined efforts to modify their behavior toward the child (becoming more lenient, or firmer, or more respectful) come from a mutual concern over what the child is saying about them.

Another aspect of the structure of the situation is the healthy competition that emerges between the parents and the expert. Parents can feel compelled to recover their child when they suspect that the child is getting more fond of an outsider than of them. Often the child was never previously permitted a relationship with an outsider, and now he has a base outside the family for changing his position within the family. Part of the merit of this outside base is the opportunity he has to help expert and parents compete for his affection. An interesting proc-

ess can develop in which the therapist becomes a "friendly contender" who lets the parents emerge the winners. (Supervisory sessions often include the problems of dealing with the jealous parent, and poor outcome can occur if the therapist becomes too jealous of the parents.)

At the same time that they are competing for affection, the parents find that the child's therapy also forces them in the opposite direction. As the child in his therapy sessions is given freedom to say and do anything he pleases, he finds that his therapist will try to put up with just about any kind of behavior. (Not only are many child therapists permissive, but to help the child express his fantasies they allow a wide range of undisciplined behavior.) Naturally, the child begins to behave in the same way at home thinking that his parents must approve or they would not have put him into that situation. Yet, even though a child therapist can be permissive with almost any kind of behavior for an hour in the office, no one living with the child twenty-four hours a day can tolerate such impulsive and undisciplined behavior. Therefore, the parents are driven to discipline the child in order to live with him. In many cases they have never effectively disciplined him before, so the child finds a more secure home life. Often, too, the parents could never agree with each other about discipline, and each attempt led to a quarrel. Now they must agree to survive when the child is behaving in such an extreme way. A fundamental rule becomes apparent in the situation—the more permissive the child therapist in the office, the more he provokes the parents to provide discipline at home. Consequently the child undergoes therapeutic change.

Related to questions of discipline and security is the change in the parental relationship with the child when he has been given over to an expert. Since the child has professional support, the parents feel more free to make mistakes and, therefore, more free to make decisions, because the therapist will make it up to the child and work it through with him. For example, parents may become free to expect the child to go to bed at the proper time, instead of having the usual evening battle, because they feel the treatment must be helping him to be more normal. As they expect proper behavior from him, the child delivers it, with consequent changes throughout the family. In this instance, the parents usually find that if they are not quarreling with the child at bedtime, they are quarreling with each other. Now they must resolve their conflicts, because the child won't rescue them as he has done in the past by making trouble in the evening.

Therapist as Extended Kin

Other structural changes occur in the family merely by the act of placing the child in therapy. If the treatment goes on long enough, the child therapist takes his place in the kinship structure by becoming a paid member of the extended family. He becomes built in as a helpful uncle or grandparental figure who emphasizes marital harmony and can, in time, offer advice to everyone in the family and not merely focus upon the child. Even at the start of treatment, the extended family structure is affected. When the parents take the child to an expert, they free themselves from the need to quarrel with their own parents about the child. The mother can say to her mother, "He's in treatment now, so I would rather not discuss his problems with you." Since the child's symptoms reflect not only the parental conflict but the conflict with extended kin as well, the introduction of the outside expert forces a change throughout the total family system. Once the child is shifted outside the focus of family conflict, he is free to change and respond more normally. The exclusion of the in-laws also fosters the cementing of the marital relationship and helps draw a boundary around the nuclear family.

When a child therapist interviews a child, he is inevitably intervening in the marriage of the parents. As one example, he replaces father as the person mother talks to about the child's problem. The complaints that used to go to the father are now directed toward the therapist; the father is displaced from the position of listening to a constantly complaining and harassing wife. With this structural shift, some of the bitterness of the relationship lessens and the spouses reach out to one another. Ultimately, the spouses can form a tighter coalition that puts pressure on the therapist for more success with their child.

As treatment continues, the influence of the child therapist upon the parents often becomes more direct, even though his contact with them is brief. One must emphasize the skill that is necessary to deal effectively with the parents while having only short contacts with them. When the mother delivers and retrieves her child, she must be influenced quickly, as must the father when he discusses the bill and joins his wife in receiving a report on the child's progress. Using what he has learned about the family from the child, the therapist has a series of brief encounters with the parents that have a cumulative ef-

fect over time. Full credit must be given to child therapists for their ability to do brief therapy and exert influence upon both the parent, child, and the marital relationship so that the child can change.

A child therapy orientation may prevent one of the most recent and common errors of family therapy—that of overfocusing on the couple and losing the child in the process. Buttressed by the popular theory that if the marital struggle is resolved, the child's symptomatic functions will disappear, some family therapists work unilaterally with the couple, failing to deal with the child as a necessary, integral part of the problem and its resolution. If they lose the child's contribution as regulator of the speed of therapy, as moderator of the pace of change (through his "when and how" of symptom increase or decrease), the child fails to change.

The Therapist's Influence on Parents

At first the child therapist may be influenced by his theory to treat the parents as only the ghosts of past introjects, but later he begins to deal with them as human beings, particularly as he becomes more fond of the child. If the therapist finds that his individual therapy sessions with the child are not effecting behavioral change, he usually feels an empathy and compassion for the parents' similar plight and thus develops a more positive relationship with them. The parents become more relaxed and flexible, and the child can have an atmosphere in which change is more possible.

As he begins to deal with the parents more directly, the therapist finds also that they ask more of him if the child is not changing. Feeling he must offer them something, he gives increasing amounts of advice about how to deal with the child. Sometimes the parents are willing to follow his advice at this stage, partly because the therapist is more friendly but also because they feel pride in their competence at having forced the advice from him. The advice is also more valuable than it would have been if freely offered.

The child therapist deals more directly with the parents when the child has begun to undergo change. The therapist becomes invested in protecting the changes he sees himself as having created. To do this, he is subtly but surely compelled to move into the larger system. This move can dovetail with the changes the child is producing in the system, sustaining and reinforcing them.

The Function of "Play"

Granting the child therapist's skillful use of brief therapy with the parents, his influence on the family does not confine itself to direct contact with the parents. He not only uses the child to gain information about the family, but he effectively uses the child to bring about change in the family. In this sense, child therapy is similar to the approach taken by some family therapists who select a key member and interview him individually, using him as a lever to bring about family change. However, child therapy has developed a unique method of influencing a family with its use of "play" with the child. It is significant that the vehicle used to enter the complicated organization of family life is the child, the most innocent and directly perceptive member.

The private playroom of the child therapist and the child is like a safety zone for both of them, although the content of the play may appear to be about unmastered experiences and the resolution of internalized conflicts. To the extent that play and fantasy mirror the actions of the family, the child learns to deal with harmful family interventions by coping with them in miniature; the therapist, who may have been appalled by the destructiveness evident in the family, becomes more inured to these patterns in play form. The child and his play become the child therapist's way of entering a family on a familiar path, with the play therapy like a decompression chamber that permits the therapist to approach the family later without too much risk and uncertainty.

Play is one of the most important factors in human life, but in child therapy, "play" is a peculiar and deviant form. By definition, play is something that occurs between voluntary participants and has no purpose except the pleasure of the action. This generally accepted definition of play is clearly not applicable to "play therapy." When play is used as a therapeutic tool, it is given a purpose and so by definition becomes something other than play. There is also a question as to how voluntary the play is in therapy; the child is sometimes brought to it unwillingly, and the child therapist is paid money to participate. Clearly it is not a spontaneous occurrence but an arrangement made with an ulterior motive—to induce change in one (or both) of the participants. Another aspect of it is also unusual; although adults sometimes play with children, it is rare to find two people playing with dolls when one of them is old enough to have a moustache.

Seen in this way, play therapy is less play in form and more of a

special communication that has different rules from ordinary life. Like other forms of therapy in which patient and therapist can play with ideas and words that would not be proper in other settings, child and child therapist can play with objects in ways that would not be appropriate outside the room. For example, if the child picks up a toy truck and throws it, an adult will ordinarily protest. The adult child therapist might pick up the truck and throw it himself, or if less active, he might at least make a permissive comment or interpretation. The usual rules of adult-child interchange are suspended or treated as a fiction in this setting.

With this kind of freedom established, there is also a suspension of the usual rules for directing someone to behave differently. The unstated task of the child therapist in the play room is to ease the child into behaving differently with adults and particularly with his parents and siblings. This persuasion is not accomplished by explicit directives to behave differently, any more than it is in most methods of therapy, but by indirection, which is more difficult to resist. As the child goes through searching behavior to define his relationship with the therapist and to find out how he is to behave, the toys in the play room become devices for trial-and-error experimentation. They not only become expressions of real family issues that can be resolved (as theory has it) in symbolic form, but more importantly, they can become a vehicle for the therapist's instructions as to how to deal with these family issues in reality. The way the child therapist responds to the child's handling of the family dolls, for example, can be an indirect instruction as to how he is to deal with adults and with the real family at home. In effect, they are remote, indirect communications to the adults as to how to deal differently with the child.

The most typical children's problems involve a contract between parent and disturbed child that the parents will demand certain behavior from the child, which he will not deliver. The child may not talk, or he may not control his bowels and bladder, or he may not learn in school, and the parents put pressure upon him to do these things. Child therapy, with its format of a nonpressured atmosphere, an emphasis on play, a loosening of rules, and so on, not only offers the child a different adult response, and so a new contract, but also a directive for how to deal differently with the parents. For example, a young child is brought to a therapist because he is restless and "doesn't talk yet." At home the parents are locked in a struggle with the child to persuade him to talk. The therapist agrees with the parents that he

will deal with the child's mutism, but actually he deals with it by offering other modalities of expression, such as drawing, plastics, and toys. With no pressure on him to talk, the child begins to speak in the play room. The therapist also draws the parents' attention to these alternative ways of dealing with the child, and so the conflict over talking is reduced. When the withdrawn child is offered the opportunity to express himself with toys, he can be less withdrawn in a new modality and proceed to behave more aggressively, first with toys and later at home. As he knocks over the mother doll and survives it in the playroom, the therapist encourages this aggression against the doll. Implicitly he is encouraging more aggression with mother. When the child is then more outspoken with mother and does not deal with her by withdrawing, mother is forced to deal with him differently, and so a different pattern is set up in the family. Yet the therapist has never asked the child directly to assert himself more with mother, he has "merely" directed his play with a mother doll. He has never asked the mother to deal differently with the child either. With older children the therapist will use other devices, such as saying to the child, "Your bad side wants to fight with your parents all the time, but your healthy side wants to be happier." Dividing up the child this way, or joining the healthy part of the ego, is a way of directing the child to behave differently without making a "request" that can be refused.

In those cases in which the child is obviously responding negatively to parental pressures, the child therapist must help the parents deal with him differently. For example, the therapist might ask the parents to be less intrusive and not pump the child but, instead, to let him have some secrets. This is easy to do within his theoretical conviction about the need for confidentiality between himself and his child patient. However, the therapist does not merely make these requests to the parents, he also uses various arts of persuasion. One of his procedures is to explore briefly with the parents their own childhood, with a compassionate view of how it has influenced their behavior with their child in ways beyond their control. Finding themselves being forgiven for their current behavior, the parents are more willing to change it. If the child "regresses" because the loose and permissive setting of child therapy facilitates moments of controlled "regression," the parents become more dependent upon the therapist. This is reinforced by handling the child's regression as a phasic event, if possible even as proof of progress, reassuring the parents in their moments of increased stress. The disappointment of the parents, which initially made them

seek treatment, is deepened and so is their need for the therapist's guidance and support. As they lean upon him more, he becomes more relevant to their family system and is more able to influence it.

One should also not overlook the importance of the play therapy setting for the therapist. In the standard therapeutic setting for adults there can be an illusion that people are rational or irrational (although dream interpretation helps overcome this myth), but the child therapist is under no such constraint and can use nonverbal communication, fantasy, etc. when dealing with his child patient. Unlike the modern family, with its emphasis on cognitive solutions to problems, or reasoning with the child, he is free to use means other than intellectual to contact the child. These nonverbal techniques also make him better able than the parents to monitor the child's pace of interpersonal development.

Because "play" is theoretically unacknowledged as a means of communication from the therapist through the child to the parents, and from the parents through the child to the therapist, child therapy respects and utilizes the family's defensive arrangement by its very definition of method. Pretending that the parents are not (through play) being given instructions and circumstances for behaving differently, child therapy avoids many current trends. It avoids frontality, explicitness, "getting to know where you are at," and any confrontative "reasoning out" of the problems. These trends are stressed as important to change in many therapies. But by using "play" and by claiming no direct influence on the parents, child therapy provides a "double masking screen" through which the proper freedom for indirect communications, so essential to outcome, is preserved.

A "modern" error of many family therapists is treating family members as if they are only behavioral contributions in unfolding interpersonal sequences. The possibility of family members feeling a measure of responsibility for their own behavior can be reduced in this format. In play therapy, the framework by itself allows family members to feel always that they are discrete and separate individuals, despite the fact that their behavior can be at the service of obscure forces, like larger multi-generational sequences or "childhood events." Because the framework of child therapy serves ostensibly to enable the child to come to terms with himself as a separate being, most processes through which the significant work occurs can only become incidental or implicit. Since the incidentals entail most communicational relays between parent, child, and therapist, a convenient situation of un-

guardedness develops; that is, all participants can keep out of the field of conscious preoccupation any rational checking of each other's intentions, while these are modified. The rethreading of parents and child into a different system proceeds then precisely by deemphasizing that they are a system at all.

One should note in passing that one of the dangers of individual play with the child is the possibility that the therapist will become too attached to the child and so threaten to detach him from his parents. As part of the wisdom of the child guidance movement, this effect was balanced by having a social worker deal with parents. Along with many other functions, the social worker could interpret the therapist's ideas and behavior to the parents and serve as a mediator while also influencing the parents to change.

When therapy fails to change the child, the child therapist who works alone becomes increasingly involved with the parents and requests certain kinds of changes in the parent-child relationship. If this does not produce results, the therapist raises the question of whether the marital relationship should be investigated and treated. This threat often is sufficient to force the parents to deal with each other differently to avoid going into their marital problems further, and consequently the child changes. The more the therapist is thwarted in his attempts to help the child change, the more he begins to inquire incisively into the nuances of the conflict between the spouses. The parents quickly shield themselves by changing their parenting, thus benefiting the child. The child himself can also initiate a fast bootstrap operation to modify his behavior sufficiently so that the parents have an excuse to withdraw him from treatment; thus the child helps protect his parents, with their marital difficulties, *by improving instead of by having symptoms as he did previously*. This kind of intervention is sometimes done by family therapists, who see the child's problem as largely a product of family conflict, but usually they help the parents work through the conflicts because they are seeking perduring changes in the child and not temporary ones. Obviously, change in the child can only persist if his family has changed.

The Contribution of the Child

Up to this point there has been an emphasis upon the parents' influence upon the child and the therapist's influence upon the family. The important influence of the child upon both parents and therapist

should also be dealt with explicitly. An example can partially summarize the child's contribution. In a family with conflict between the parents over who was superior to the other, their child was caught between them as a vehicle for this conflict. The mother insisted that the child be outstanding in school as part of her attempt to set the child up as a competitor to her husband, whom she considered weak and unsatisfactory. The father responded to the child's achievement by indicating that the child was siding with the mother against him and humiliating him. The child responded to this situation by manifesting an acute fear of homework, thereby being unable to achieve in school for reasons outside of his control. When he entered child therapy and began to relate in a positive way to the therapist, his problem was increased. To please the therapist, he must lose the fear of homework in the context of play with this safe and significant person. As happens in many such cases, the child improves, but the family has not significantly changed. The child then either relapses or offers different symptoms, such as other fears, headaches, etc. Often the therapist sees the "regression" of the child as part of the transference aspect of treatment. However, in terms of his actions, the therapist shifts his strategy with the child and also becomes more involved in "management" interviews with the parents, partly to persuade them to deal differently with the child—"We mustn't rush him so much"—and partly to gather more information about the home setting in order to understand the child's difficulties. In the process of canvasing the field for more information, the therapist can seldom fail to insinuate a paradoxical situation as well. He can talk about the regression in such a way that its implications for signaling therapeutic gains cannot be ignored. Almost everything the child does and alarms the parents can turn out to imply the possibility of immediate or impending progress in an unfolding process. This keeps child and parents firmly bound to the situation. Either the therapist's "brief management" interventions then steer the parents in a radically different direction, or the regression so intensifies that it pulls the parents into behaving differently with the child, or eventually the child's maturation ushers in a new developmental stage changing the regressive behavior.

From the point of view we are describing here, "regression" can be seen as a progression of the child to a more effective way of communicating with the therapist. He is responding to the therapist's lack of understanding by trying other means to influence the therapist to modify his situation, particularly the parental behavior. Symptomatic

behavior, and play, are the child's way of indirectly instructing the therapist to shift his strategy of therapy. If the therapist does not understand, the child will communicate by more severe symptoms, as if using a megaphone, until his influence is successful in activating the therapist and the parents to behave differently. His severe symptoms encourage the parents to seek counsel with the therapist and encourage the therapist to enquire further into what is happening at home. When the sensitive therapist picks up the child's cues and modifies his approach to child and parents, the conflicts in the family become resolved and the child is free to give up this form of communication. At this point, neither symptomatic behavior, which the child has learned to use in his family, nor the "play" therapy, which the child has learned from the therapist as a way of communicating, is necessary.

In terms of the relationship between therapist and child, a mutually regulatory pattern becomes established. When the therapist is flexible enough to heed the child's message, he demonstrates his respect for the child's autonomy. He communicates to the child, "Your communications have power." A level of respectful reciprocity within the interdependent relationship is attained, and autonomy is now feasible for both. The autonomy of the therapist, as well as of the child, is in this sense an eventual product of an underlying collaborative dimension. This dimension is achieved by child and therapist testing each other for impact of communications, without perceiving themselves in a complex relay system of more than two persons. Evidence that communicational cues beyond the two of them are being effectively relayed and received may show only in non-verbal indicators of collaboration. There is room for behavior shifts on the part of both—the therapist to modify his strategies, the child to change his deviant behavior, neither feeling necessarily conscious of dealing with more than one person.

The Family Orientation

It was once thought that perduring change in the child could occur only if in addition to child therapy, both parents were in individual therapy. Sometimes it was assumed that treatment could be coordinated by collaboration among the several therapists of the different family members. Such collaboration usually failed, and typically the individual treatment did not resolve the marital struggle in which the child was entangled. From the view offered here, it would seem that treatment can be most effective and efficient if the person treating the

child also "manages" the parents so that change in the different parts of the family system at different stages are coordinated by a single person.

Many child therapists continue with the procedure of alternate interviews with child and parents, and this way of approaching families has many merits. In some cases parents can react with resentment and resistance if they are directly confronted with family conflicts the child is expressing. Advice offered by someone who is clearly not blaming them because he feels the child has a problem inside of himself can often lead the parents to accept directives and respond in new ways with less resistance. In this sense it is the very fact that the child therapist acts naïve about family dynamics that sometimes makes his influence upon the family effective.

WHY CHILD THERAPY FAILS

What has been emphasized here are those aspects of child therapy that have merit if viewed from a family orientation. Yet, if one grants these merits, one must address the question of why child therapy and child analysis do not usually succeed in bringing about therapeutic change. It can be argued that the naïveté about the context of the child helps the child therapist correct errors of family therapists who are overfocused upon the marriage and neglect the child's contribution to the problem and to the therapy. Yet being naïve also causes change to come about inadvertently instead of predictably, and, therefore, treatment failure is as likely as treatment success.

There are two main handicaps for the child therapist, both of them related to the theory he is taught. The first handicap is, of course, the idea that the problem is within the child. Although this theory helps the child therapist be less blaming of the parents, it is also likely to cause him to neglect the parents after the fee is set. If his theory persuades him that he is trying to change something within the child, he will not communicate to the parents through the child but will merely pass the time playing with the child, and no change will take place.

The second handicap is based upon the child therapist's lack of understanding of the ways the child is responding to his interpersonal context. If the therapist takes the child's communicative behavior only as a report about his inner nature rather than a report about his social situation, the therapist will not direct his efforts toward deliberately influencing the social situation so that the child can change. While it is

true that by not forcing the family to deal with the parental conflict, he may avoid the consequent bad feelings among the family members, he will be like the behavioral modifier who brings parents together around a new conditioning program without ever realizing that previously the parents were in conflict about how to deal with the child. Yet, by not knowing that the child is responding to a conflictual family structure, the child therapist will not be able to indirectly influence that structure in any *systematic* way. If he does have an influence, it will be a chance occurrenee, and so therapeutic change will occur by chance.

When a social worker is dealing with the parents while the child therapist treats the child, there is a chance of an influence on the family through the social worker's endeavors. However, there is also a chance that social worker and child therapist will be in covert conflict with each other about the family, taking sides in family struggles, and will merely replicate the conflictual situation that has produced a disturbed child.

SUMMARY

Despite the many theoretically based factors that can cause treatment to fail, one should not overlook the fact that the child therapist approaches symptoms within the newer theoretical model developing in the field. Previously, it was assumed that a patient's symptoms should not be dealt with directly because they are supposed to have "roots." Child therapy offers an alternative view: focus on the child, or symptom, acknowledge the roots of pathology in the family, but do not deal with the roots directly. In the last few years this approach has been considered innovative in the treatment of symptomatic adult behavior, such as phobias or compulsions. Such symptom-oriented therapies as behavioral conditioning, the paradoxical intention approach (1), Milton H. Erickson's methods (2), or Stampful's procedure (3), all assume that the symptom should be dealt with directly. Some of these approaches emphasize not only focusing upon the symptom, but even encouraging it as a way of bringing about change.

Clearly child therapy has anticipated these innovations and is in the *avant garde* of the field. When the child therapist accepts and encourages the family's presentation of the child as the problem, he is accepting the scapegoat function of the child without arousing resistance in the family. This approach leaves him free to convey effective sug-

gestions in his brief contacts with the parents. Whether he conveys those suggestions to bring about change in the family and consequent change in the child is partly determined by chance since in the nature of child therapy theory it must be unplanned.

REFERENCES

1. FRANKL, V., "Paradoxical Intention: A Logotherapeutic Technique," *Amer. J. Psychother.*, 14: 520–535, 1960.
2. *Advanced Techniques of Hypnosis and Therapy: Selected Papers of Milton H. Erickson*, Haley, J., (Ed.) New York, Grune & Stratton, 1967.
3. LONDON, P., *The Modes and Morals of Psychotherapy*, New York, Holt, Rinehart and Winston, 1964.

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