apy and that helped too. However, the chaos at home always threatened to undo the gains made in therapy. I can only imagine how much more disturbed Timmy would have been without psychotherapy. I never did prescribe any medication.

In conclusion, it is not enough to look at the symptoms the child displays and plug him into a diagnostic category. Rather, you should try and understand how the primary needs of the child interact with his essential others and with his imagination to create self-structure.

5

Principles of Treatment

I now turn to the basic techniques and guidelines for treating children from a self psychological point of view. The goal of therapy, I believe, is to facilitate the growth and maturation of the child's self, specifically, to help the child develop healthy primary and secondary self-structure.

My focus has been individual psychotherapy, reflecting my belief that no matter what the technique, it is the individual self of the child that must remain at the center of the therapy. Also, parental guidance and family therapy often have their limits. In many cases it is only in the dyadic therapeutic relationship that the child's self can be freed up to respond to the improved selfobject milieu at home. Further, even if the parents are in intensive therapy themselves, their own growth and maturation as effective selfobjects take time. During that period the child's needs must be met and he must be helped to survive in order to stave off further damage.

The backbone of all self psychological psychotherapy is the creation, repair, and maintenance of a growth-promoting selfobject bond. This follows the same basic route as that described in the adult literature. First,

there is an attempt to develop an empathic understanding of the patient's material. Then, there is a communication of that understanding to the child in a way that he can understand. This creates a selfobject bond between patient and therapist that is intrinsically growth-enhancing. The patient's self, perhaps for the first time ever, is at the center of someone else's universe. The child's Will To Do, Principle of Internal Harmony, and Need For Others begin to be met in new ways. It is rare for a human being to be the center and exclusive focus of another's attention. In the family the child's needs are always balanced against the parents' and siblings' needs. Psychotherapy offers a superheated focus that—even at only one or two hours a week—can provide what is unavailable elsewhere.

But, inevitably there will be empathic failures on the part of the therapist, and the special growth-sustaining bond will be disrupted, resulting in fragmentation. It is essential that evidence of fragmentation be recognized and the cause discovered if the bond is to be restored and growth continued. Failure to do so can result in trauma. Simple recognition and understanding of the cause of the fragmentation, particularly if it is related to something the therapist did or did not do, and communication of that understanding to the child, can often go a long way toward repairing the bond. When the selfobject bond to the therapist is restored the self of the child will reintegrate, sometimes in an improved way. This idea of multiple fragmentations and restorations of the therapeutic alliance is the cornerstone of therapeutic change in Kohut's original theory. It is here that frustrations are made optimal and "transmuting internalization" occurs.

Other writers emphasize optimal gratification or optimal responsiveness as more important to self growth than frustration. Here the frustration may be only important in revealing the self-structure that has already been laid down through a prolonged period of optimal responsiveness or emotional attunement. Frustrations, though present in every therapy, are not necessary for psychic growth in their view.

My own view combines both perspectives. I believe significant growth occurs during the period when the patient feels attuned to. Nevertheless, I also believe that frustration does more than just reveal what was already there. Frustrations, if they are within a tolerable range for that patient, stimulate the patient's Will To Do. Like the mother bird pushing the baby out of the nest, they encourage the patient to make use of the self-structure he has gained. Often this involves the creation of secondary selfobjects and subsequent secondary self-structure formation. A simple way of saying it would be that optimal gratification stimulates primary self-structure development while optimal frustration stimulates secondary self-structure development. Hence, self-growth occurs in a therapeutic window between optimal gratification and optimal frustration.

Secondary self-structure formation is also aided by the creation of a growth-promoting milieu. This involves both the adoption of an empathic mode of listening, and the creation of a space where the child feels free to play out his fantasies. How much the therapist becomes a part of that play, and in what way he contributes to the evolution of the child's fantasies, are all important factors in secondary selfobject creation. Finally, the child may come in with a maladaptive or negative secondary self-structure that must be dealt with before new self-structure can be laid down.

In all cases growth depends on a positive primary selfobject background. Repairing that bond when it fails and actively maintaining it between failures is an essential part of self psychological psychotherapy.

Now let us look in greater detail at the creation of a good positive primary selfobject milieu within the therapy. My first recommendation is that you treat your patient as you would want to treat your own child if you were at your most cohesive. Listen to what the child is trying to convey and don't let the historical material get in the way. Don't try to be too technical or fancy. Get to know the child. If the child does not talk, try asking a few questions. If the child does not respond to questions, stop asking them and just play for a while.

Doing psychotherapy has a lot in common with raising a child, but with a different emphasis. Therapy provides a total focus on the child's feelings, a greater stress on empathy and, in general, a lesser one on limit setting. All the normal functions served by parents are present including validation, understanding, admiration, being an ideal, setting limits and rules, among others.

Listen and look for what the child is feeling. What are the predominant affects? First, ask the child what he is feeling. If the child does not respond, which is often the case, then take your best guess: "I imagine that it is hard for you when your father goes out of town like this, and that you miss him." Then listen and look for the child's response. Often it will not be given directly but metaphorically. The child may say "I'm used to my dad being gone, it doesn't bother me," then draw a picture of a spaceman whose lifeline broke and who is drifting off into space. You could then ask him about the drawing and what the spaceman is feeling. Your patient may be able to speak much more freely about the spaceman's feelings than his own.

Children often deny feelings, or admit to just one feeling, such as sadness, and use that feeling as an answer to all questions. Sometimes it is helpful to say "I could see how it would make you sad when your brother breaks your toys, but I can also imagine that it might

make you angry as well." This must be done carefully, however, because it is easy to fall into the trap of not hearing what the patient is conveying.

Children defend against intolerable affect states. They may use sadness to cover anger or anger to cover despair. They may have never learned to talk about what they feel most deeply because those feelings were not validated or accepted at home. Helping them put names to their feelings can improve their self-cohesion. Although you may prefer to let your adult patients find the words to express their feelings, and although this is preferable with children as well, it is often not possible. By suggesting certain feeling states to a child you run the risk of muddying the waters and ruining your chance to see what is really bothering him. On the other hand, you have to face the fact that with some children you will never see what is on the bottom of the lake unless you dive in. There is a balance that must be found. As a supervisor once told me, "If you aren't in up to your ankles you are not in enough, but if you are up to your neck you are in too far."

As you acknowledge what the child is feeling, you are affirming aspects of his self. If those aspects had been split off before, they now have a chance of being integrated with his core self. The next step is to try to identify how those feelings arose. What is happening in the therapy that might be triggering those feelings? Does this connect with what is happening at home or what has happened in the child's past? Often there are central issues that make the child sensitive to particular interactions in therapy. A common one is frustration of the Need For Others early in childhood, resulting in both an intensification of that need and a reactive rage. The rage leads to a fear of retaliation—"If I feel this angry, those big adults can too, and that would be really scary." If the anxiety is too great, the feelings may be split off from the

core self to take on a pathological life of their own. Different symptoms may result. Which ones arise will depend on the self-structure of the child at the time.

Central issues from the past can be triggered by events in the therapy. For instance, when the therapist leaves for vacation it may stimulate all the old feelings of frustration that the child had known previously. This can cause a worsening of symptoms. It is compounded by the fragmentation one might expect from the loss of a needed selfobject connection. Understanding this can help repair the damage after the vacation by addressing these issues with the child.

Patients often show evidence of self-state changes at the beginning and end of sessions. This is another example of how an aspect of therapy, in this case the very framework, can trigger old feelings by pushing on fracture lines. The balance between hope and dread shifts throughout the session. Careful analysis will often reveal a characteristic set of self-state changes from the moment the patient enters the office to the moment he leaves.

Other common triggers of fragmentation include the therapist coming late to sessions, canceling sessions, and not being attuned to the child's needs. If a child is brought early by the parent, it may feel to the child like he was kept waiting, which can have a similar effect on his self-state.

Clearly, it can be helpful to have an understanding of a child's past in anticipating or understanding fragmentation within the session. But it is most important to stay within the child's frame of reference and not get lost in historical data.

As you gain understanding you must decide what to do with your new insight. What level of understanding do you communicate to the child? Usually, the ego-psychological maxim of interpreting from the surface is helpful. However, it is not always easy to figure out what

is closest to the surface. One helpful technique is to ask yourself, "What does my patient want right now?" If a child is trashing your playroom it seems to make sense to say "I think you are very angry with me now." However, that will often intensify the destruction as the child's destructive feelings are validated but the cause of those feelings is left untouched. The next step might be to say, "I think you are angry with me because I went away." That might evoke an acknowledgment but the destruction will probably continue; this is because the affects connected with the vacation have not yet been traced to their roots. You might say, "I think that our meetings are very important to you and when I went away you felt abandoned and hurt. Right now you want to show me how much it hurt and how angry you are about it." It may take several variations of this before the child will respond. Some children may not easily let their guard down to directly admit to such feelings but they will have heard that you understood them. That sense of being understood is a crucial component of a positive selfobject milieu, which is essential to both primary and secondary selfobject formation. Of course, it may be necessary to limit the child's behavior before it is possible to get him to hear an interpretation.

Now that we have reviewed the importance of making, keeping, and repairing a sense of empathic attunement to the child I wish to list some more specific recommendations.

METAPHORS

Get used to working in metaphors. Few children can talk about their painful feelings directly, especially at the beginning of therapy. Hence, it is helpful always to consider what the meaning is behind the child's play or seemingly

irrelevant comments. For instance, the child who drew the spaceman drifting alone in space was telling me a lot about how he felt when his father was not around.

In general, it is wise to make direct interpretations linking the patient's play to the outside world only when it seems that it will further the patient's development. Any interpretation at all, any stepping outside of the play, can be felt by the child as an empathic break, or even as an assault on his self. It is better to spend a fair amount of time within the metaphor of play first. With time, small linkages to the child's life can be tried. If they are tolerated reasonably well, if they seem within the realm of optimal frustration, then they may be enlarged upon. One exception to this is when the changes in the play seem to be a result of a disruption of the therapeutic bond. In that case, I would make the connection immediately to put the therapy back on track. Another exception is when the child seems clearly ready to talk about his life.

A good initial assessment can be helpful in trying to understand the child's metaphors. Equally important to this understanding will be a consideration of what has been happening between you and your patient. Not only is that often relevant, but places where the child's material is determined by something that happened within the therapy carry with them the powerful emotional force of the here and now when they are interpreted. In a way, doing psychotherapy is akin to reading and writing poetry. You have to be able to find the emotional meanings behind the words and actions. Then your patient and you can proofread, edit, and recreate.

HIGHLIGHTING AND COMMENTARY

A helpful technique to begin to identify what is going on in the session is something I call highlighting. This is

derived from another technique that has been used by child therapists for years—the running commentary. In the running commentary you verbalize what is happening in the session as it happens. This facilitates the process of transforming unintelligible action into a discussion of feelings and thoughts. I sometimes use it as an emergency measure when I feel totally lost within the session. At the very least, it helps me organize my thinking and focus my attention. It may also be helpful in reinforcing a sense of continuity to the child and may provide him with a similar organizing focus.

Highlighting is similar in that it involves a verbalization of what is happening in the session. Unlike the running commentary, however, the verbal comments are fewer and are chosen to emphasize certain aspects of the material. For instance, if at the beginning of the session my patient hides from me and partway into the session he has one toy man hide from another, I might say something like: "When we started the session you hid from me and now the man is hiding." Here I have brought to my patient's attention a common element. I don't make any interpretation of what the hiding means, I only acknowledge that it is present. Typically, I would have preceded it with questions about why the man is hiding.

In the above example, I was highlighting an element of the play that was common to both the miniature world of the toys and to my patient's interaction with me. Repetitive elements are important to recognize as they tend to reflect something of the way the child is organizing experience, hence, something of his self-structure. In addition to highlighting repeated elements in the session, it is useful to make note of anything that seems to occur around self-state shifts.

The child's self-state, at any given moment, is determined by the relative influence of various primary and

secondary selfobjects. For instance, the child may be partly sustained by the relationship he has with his therapist, while also utilizing a fantasy of being Superman to boost his cohesion. Furthermore, the secondary selfobject image of Superman may be strengthened by a fantasy that his therapist is like Superman's father. Because of these primary and secondary selfobject influences, the boy feels cohesive, continuous, powerful, and good. Then the therapist unempathically introduces the idea of kryptonite—a substance poisonous to Superman and his father—perhaps pursuing an erroneous hypothesis. The child stops playing Superman with the therapist, moves across the room, and begins running over army men with a toy car. This clear change in self-state from one of ebullience and interactive play to one of self absorbed motor vehicle mayhem was triggered by the therapist's introduction of kryptonite. It deserves to be highlighted.

Many times it is helpful to highlight in your mind without saying anything to the child. In fact, most of the time this is preferable. Highlighting to yourself gives you a chance to see patterns and to gain understanding. Once the understanding is achieved, you can decide how to use it to best help your patient. This can include an empathic communication to the child, a suggestion to the parents, a communication within the metaphor of the play, or an alteration of the interaction in other ways.

THEME AND SUMMARY

It is helpful to note the recurrent themes within the child's play, stories, or actions. Repetitive elements of the child's material suggests that those elements have particular meaning for the child. By identifying what is

common between the parts that are repeated you may gain entrance behind the metaphors. Finding the thematic meaning in a patient's material has been called following the "red thread" (Saul 1985). According to Saul, each session has within it a dominant theme or "red thread." The task of the therapist is to identify that thread and, if interpretations are to be made, they ought to address that thread of meaning. In my experience, it is not always easy to find the red thread, but it is helpful to try. The red thread becomes easiest to see when there are disruptions in the therapy. Then themes of loss and fragmentation are often obvious and interpreting them is important. Always ask yourself, "What did I do to bring on this change in the material?" After you have considered that, then ask yourself what outside of therapy might be contributing.

Identifying the central theme in each session then becomes the basis for making a summary at the end. Most of the time a summary is not needed, but it can be a helpful way to encourage the development of a sense of continuity and cohesion between sessions. It can also be another way to communicate empathic understanding to the child.

Summaries can also be made at various intervals within the session in a similar fashion to highlighting and commentary. This can be especially helpful in shoring up the therapist's cohesion and in helping him maintain his attention within the child's frame of reference. At times, we can all use help to keep our minds tuned into the child's experience.

PLAY

Don't be afraid to play. It is easy to feel guilty when you are playing—as if you are not doing your job. Of course,

it is easy to lose your therapeutic stance in the regression of play. You need to be able to step back from time to time and ask yourself if what you are doing will further the therapy or not. But with children you cannot stay in your chair and observe. They won't act the same if you do. I believe they won't make the same progress either. The child grows as a function of the therapeutic relationship, which is a significantly different relationship when the therapist actively joins the child in the play. While you must frequently ask yourself if you are fulfilling your own needs and avoiding the real therapeutic issues, sometimes being a part of the play is the best path to those issues. Be a participant observer, not a sports commentator. Again, the trick will be to find the right depth of involvement—somewhere between ankle deep and up to your neck—that optimally promotes the child's self growth. In doing this it is helpful to follow the child's lead.

Following the child's lead ensures that you will remain empathically tuned in to the child's inner world rather than your own. Hence, even though I don't recommend sitting back and taking notes, I also don't recommend a directive approach. The first precept of a self psychologically oriented approach to therapy is to try to remain empathically immersed in your patient's world. That is hard to do and requires constant effort. Only after a great deal of time is spent exploring the child's inner world does it make sense to take the lead through an interpretation, an addition to the play, or an action.

If you have been immersed in the child's material long enough, following his lead, you may find yourself spontaneously adding something to the play. The question of whether it is alright to directly add to the play is an important one. On the one hand you do not want to "contaminate" the patient's material with your own. On

the other hand, the idea that you can somehow produce a sterile world in which to examine your patient's mind is both wrong and undesirable. The most straight-laced analyst, who rigidly refuses to speak when his patient needs him to, is creating an environment that is experienced as very slanted and alien by most people coming into therapy. Each one of us cannot help but reveal ourselves to our patients as we work with them over time. So, in one way or another, we all add to what the patient is creating. Yet, it may be argued, to go beyond what is unavoidable and to deliberately take the lead in the session may be another issue. I agree that it is. I consider it similar to making an interpretation. In either case you are taking the lead, communicating something of your point of view, hoping it will add to your patient's growth.

Although interpretations tend to be given after much deliberation and preparation, this is not always the case with additions to the play. When it is the case, the addition is equivalent to an interpretation made within the metaphor. But there are many instances in which the addition is a spontaneous response of the therapist's self, conscious and unconscious. This is partly due to the regressive nature of play and partly because play can move very quickly and has multiple levels of meaning.

Talking therapy tends to be more limited in the amount of information that can flow at any one time. Because play involves all the senses it has many more obvious levels. This makes it easier to understand than speech, but harder to address. At times it seems that the only way to keep up with all those levels is for the therapist to allow himself to respond in kind. That brings with it considerable risks, because the therapeutic communications between therapist and patient become too fast and rich to be processed consciously at the

time that they occur. It is only in retrospect that they can be consciously appreciated.

On reflection later, you may realize you were unconsciously communicating to the child in an empathic and helpful way through your actions. You may also have added something that the child was ready to use—but was having trouble finding by himself—in the construction of a viable secondary selfobject. On the other hand, you may find that you were reacting out of your own frustration in a way that was deleterious to the therapy. It is important to review what we do so that we can learn about ourselves as we try to become better selfobjects for our patients.

Although playing with the child rather than just observing the play has risks and complications in excess of those with talk therapy, it also has great rewards. Play is the way a 5-year-old learns about the world and constructs his internal reality. Play is the primary way secondary selfobjects are created, refined, and laid down as self-structure. Talking can enhance this process but it cannot replace it. Only by joining your young patients in play will you be able to enter their world and attain the empathic introspective stance that promotes self-development. Of course, this is especially true of children in preschool and early grade school, but it can be important even with some young adolescents.

I find it helpful to look at the child's self-state fluctuations both within each hour and across a number of hours. As I mentioned previously, the child's self-state changes in response to fragmenting influences. Signs of fragmentation are important to look for as they may reveal areas of fragility within the patient's self-structure, ruptures in the empathic bond with the therapist, or negative selfobject influences. However, changes in the child's self-state also occur as the child's self-cohesion is restored or enhanced. While focusing on

times of fragmentation can help identify areas of vulnerability, focusing on occasions of restoration can show what the child needs in order to heal.

One clue to a self-state change is a change in the quality of the play. Erikson spoke of three types of play: autocosmic, microcosmic, and macrocosmic. Autocosmic play is solitary play without obvious symbolic meaning. It might involve spinning a top over and over. Microcosmic play is when the child builds a small universe with toy soldiers, toy cars, and the like, without interacting with the therapist. Macrocosmic play involves an interaction between therapist and patient. The child's shift from one type of play to another is significant. It may mean a break in the empathic milieu or signal increased cohesion.

If a child builds a structure with Legos, or draws a detailed picture, his creation can be looked at from several angles. One approach is to explore how it might relate to his life outside of therapy. Another is to focus on what it might say about his perceptions of the therapeutic relationship. A third approach is to view the construction as a concrete depiction of his self-structure. The different parts of the self, and how they interrelate, are often graphically shown. Work on the construction may then become a metaphorical way of improving the cohesion of the child's self-structure.

The growth of secondary self-structure is facilitated by all the measures and techniques already mentioned. But there is an important difference as well. Secondary self-structure grows through the child's play and fantasizing. The purpose of play is secondary self-object elaboration and integration. The therapist must first provide an environment in which that play can exist. Then he must address the fact that often the play will not unfold spontaneously or in a positive direction. There may be much negative and ambivalent self-structure already

present, which interferes with growth. This will have to be dealt with before healthy development can resume. Conflicts will need to be untangled and the various components validated and realigned within the overall self-structure.

Before moving on to clinical examples, I want to emphasize one point that is usually omitted in textbooks on therapy. It is important that you show an interest in the child. This is not always easy. Sometimes patients are boring; sometimes they are infuriating. But if the child is to improve, you must forge a positive connection with him. I recommend not taking notes during sessions other than for the initial evaluation. Although it may be possible for some children to view this as a sign of interest, it is more likely to be seen for what it is—an intrusion of the therapist's needs into the child's space.

Now, let us review the key points already made:

1. Try to empathically immerse yourself in your patient's inner world. Much of this will consist of endeavoring to understand the metaphorical meaning of your patient's stories and play.
2. Stay within that inner world, even though that will be hard to do. Try to avoid stepping outside it to give admonitions, lectures, or instructions. Leave those to the parents and teachers.
3. Set appropriate limits when these are necessary to preserve the therapy. However, no matter how much the parents may seem to want you to, you are not there to provide the discipline that they do not.
4. Avoid premature interpretations, but don't miss episodes of fragmentation due to something within the therapeutic relationship. If you find yourself making a lot of comments ask yourself why. It may be the child's anxiety you are reacting to, or his emotional hunger and neediness, to which you are unconsciously responding by feeding him words.

5. Watch for self-state changes and try to sort out what is triggering them.
6. Always keep a sharp ear for evidence of fragmentation around vacations, when you are late to a session, or when the patient misses a visit. Focusing on the fragmentation offers a chance to repair the empathic failure and get the therapy back on track.
7. Fragmentation products to look for include: reactive grandiosity, rage, autistic reverie, hyperactivity, anxiety, withdrawal, alienation, and the wish to stop treatment, among others.
8. Self-state shifts may also reveal an increase in cohesion.
9. Participate in the play but follow the child's lead. Evaluate departures from your usual level of interaction.
10. At all points in the therapy try to do what seems most likely to promote healthy self-growth.
11. Think of the simplest explanation first and give special credence to what the child tells you directly and indirectly.
12. Above all, be a kind human being who is interested in the child.

WORKING WITH PARENTS

It is usually understood that the younger the child is, the more the parents will be involved in the treatment. This makes sense because the parents are obviously very important as primary selfobjects to the young child. But it would be wrong to assume that parents are necessarily serving less of a role with teenagers. Some theoreticians advise not meeting with the parents at all. Others, like Anna Ornstein, advise using the individual meetings with the child to inform the family therapy, which is where the real action of therapy occurs. Many child analysts hold to a formula of four visits a week with the child and once a week with the parents. And there is the issue of whether or not the child is included

in meetings with the parents. Some people feel that not including the child invites suspicions of breaches in confidentiality, while others feel that to include the child risks humiliating him.

I don't have a firm rule about meeting with the parents, or about including the child. I try to imagine beforehand what will most likely further the therapy. Whatever I decide, I look for the child's reaction and adapt accordingly. I have had some cases where my meeting with the parents has provoked jealousy and rage, and others in which my failure to meet with the parents more often has meant an end to the therapy.

In general, it is helpful to have regular meetings with parents for several reasons. It provides you with an important source of information regarding symptoms, grades, social adaptation, and improvement or decline outside of the treatment hour. It gives you a chance to help the parents act more effectively as positive selfobjects, or to decrease the amount of negative selfobject influence they yield. Finally, it builds an alliance between you and the parents that has a cohesion enhancing function for all concerned, and that makes it less likely that the parents will arbitrarily put an end to the treatment. However, such meetings come at the potential cost of diluting or seriously damaging the therapist's selfobject bond with the child.

There are several special cases that should be considered. The first is that of the parent who really needs individual therapy for himself. In such a case, I would advise against your being both the child's therapist and the parent's. It is hard enough sorting out all the powerful feelings that will be stirred up within you during the child's therapy without having to struggle over issues of competing allegiances. As therapists we are effective for our patients in as much as we can be good positive selfobjects for them. We should try to limit those things

that will likely interfere with our own cohesion in the office as much as possible.

While it may flatter our grandiosity to think we can handle conflicting alliances, if we are to help our patients, we must be emotionally on their side. There is no such thing as neutral in the emotional world. This doesn't mean that we collude with the child's maladaptive wishes, just that in the self–selfobject matrix of therapy they become a part of our self as we do of theirs. On one level, our patient's jealousies and rivalries become our jealousies and rivalries. Although we can treat a number of unrelated patients in this way, you can see the obvious problem with treating two people who know each other.

Furthermore, although the child may have no objections at the outset to your treating his mother as well, this is likely to change. It will be natural for him to wonder who you like more, who matters to you more. This is especially true when it is his parent who pays the therapy bills and has ultimate control over who will be seen. In addition, it can foster a sibling like relationship between parent and child as they both vie for your attention, undermining the establishment of a healthy parent–child relationship. Finally, confidentiality concerns will be heightened by the more frequent and intense contacts implicit in psychotherapy versus parent guidance.

The same rules that apply to not treating the parents apply to not treating siblings. I want to remind you that I am speaking of pure individual therapy here, not family therapy. However, there are instances where the therapy evolves into a hybrid and you must simply make your way the best you can. At such times, every deviation deserves careful consideration.

Another predicament that may arise is presented by the parent who is really seeking help for himself under

the guise of seeking child guidance. Many of these individuals do not take kindly to suggestions that they go into therapy. If it looks like it will ultimately benefit the child, my inclination is to work with them as they request. With time an alliance and trust will be built that will make it much more likely that they will be able to hear a recommendation of therapy. At the very least, they stand a chance of becoming better selfobjects for their children. Although this may seem to go against the principle of not treating both parent and child, it is sometimes true that if the needs of the parent are not met there will be no therapy of any kind.

If family therapy is indicated, it is best to have someone else provide it. I am aware that there are some who disagree. However, family therapy presents the same problems of jealousy and allegiance. I have had occasion to do brief family interventions first until the home situation is stabilized and then proceed to the individual therapy, but I wouldn't recommend doing both simultaneously.

I want to emphasize that we have a great deal to offer the child by focusing exclusively on his inner world. There has been no other time in his life, except perhaps during infancy, when someone else has tried to immerse themselves so purely in his reality. That feeling of another really trying to understand you over an extended period of time is the most powerful tool we have to aid the growth of the self. Do not trade it away lightly for the sake of covering all the bases. Let someone else address the other components. Focus on the child and stay within his world.

Part Three

CLINICAL EXAMPLES