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Vera Denty

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## Problems in Play Psychotherapy

Vera Denty, M.B.P.S.

Playpsychotherapy originated with Anna Freud and Melanie Klein as a child psychiatry assessment- and treatment-method and is now part of many Child

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*Vera Denty is a London University trained Child Therapist of many years experience. For the last four years, she has been the Child Therapist, Ioview Clinic, Toronto. She is also much in demand as a lecturer at colleges and libraries in the Ontario area.*

*Vera Denty's article deals with recognizing and alleviating neurosis in children. She observes that "in the Playroom, the child runs the whole gamut of humanity's emotional-ethical development."*

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Guidance Services the world over.

The writer's clientele ranges from children aged two to ten. They comprise the whole spectrum of developmental- and behaviour-problems, psychosomatics and neurosis.

Since children do not develop in a uni- or bilateral fashion, the question often arises, whether, when faced with certain phenomena, are these due to delay, i.e. the 'not yet,' regression, fixation, inhibition, neurosis, psychological factors, such as hyperkinesis, minimal brain damage, etc.

B., aged four, when three months old, suffered a skull fracture and showed scars of fractured ribs. Convulsive seizures occurred and repeated treatment for Subdural Bilateral Hematone was required.

He was placed with fosterparents who eventually adopted him. Presently his right hand functions on the level of a 3½ yr., and his left one that of a 2½ yr. old. His full-scale I.Q. is sixty-eight.

How far is it possible to develop this traumatized child by means of Playpsychotherapy?

Sometimes the child's behaviour is the result of the parents' own personality — or marital problems. Are we, as child therapists, justified in investigating the latter, so as to help the child,

when, as is often the case, the parents want no intervention in their own lives?

K. is 8 years old. His play consists of monsters fighting each other, cars and trains crashing, lightening striking people dead, snails crawling all over people.

He fights his playmates, is severely destructive with his toys, has temper tantrums at home and in school.

His father is a violent man. Although the parents are separated, he visits and 'bashes Mum about.'

His mother claims that she has 'the right to a life of my own.'

It is being rumoured that she takes the boy with her on her promiscuous safaris.

She refuses discussing her life or to change same, although she realizes that this is the main cause of K's problems; nor is she willing to give up K; the worker also feels that even if she were to do so, it would drive her even further into sexual adventures.

In some instances, the child's neurosis — contrary to expectations — is the factor that maintains the parents' emotional balance. Thus we are faced with the issue: help the child and one, or both, parents suffer a mental breakdown.

T., aged six, was referred by the school as 'severely disturbed.' She used to 'freeze' in Junior as well as Senior Kindergarten, continued so doing in Grade one, spending most of her time standing along a wall, thumbsucking and quietly crying.

She repeated this pattern in the playroom for the first eight sessions, in spite of her mother being present.

It was noted that mother, during all that period, maintained complete eye-contact with her and continued so doing even after I finally

managed to involve T. in play.

Eventually T. would come into the room on her own and 'went wild,' racing from one toy to another, until finally she settled down to more normal play.

Mother had had a brutal father and an unloving mother. She left home at the age of fifteen. She married her husband as 'the first human being who took a personal interest in me.'

Now the marriage is affectionless. 'Tracy is the only thing that I have got,' although she has a baby boy, but who, evidently, does not fill the mother's need for affection.

T., having learned independence, is functioning on a normal six year old level. Mother went through a period of depression, and whilst consciously proud of T's progress, mother herself is increasingly giving the impression of 'little girl lost.'

### Family Secrets

Gaining a child's confidence is no easy matter. When the child reveals to us family secrets, the handling of which are vital to the child's recovery, are we entitled to discuss these with the parents, risking that the parent either turns against the child or refuses the child the chance to continue treatment?

L., aged eight, has temper tantrums in school and is demanding and 'fresh' at home.

Her play was mainly occupied with people getting married, having 'lots and lots of children,' with great emphasis on L. deciding as to who is marrying whom and how many children they are to have.

In real life, L's parents are her grandparents, and her sister is her mother.

L. is legitimate. Her father still visits. She knows him as an 'uncle.'  
Her sister/mother lives common-

law with a man who has only fathered one of the three illegitimate children of the 'sister,' the other two being the product of intercourse with fleeting acquaintances.

When it was suggested to L's parents/grandparents — who are young-looking — that part of L's problems stem from her dimly having guessed the situation and being totally confused in consequence, and that therefore it would be important to give L the true facts, they refused, commenting that 'the true facts are none of L's business,' and of the two alternatives, prefer her acting-out behaviour.

On some occasions, parents and school try manipulating the therapist into a weapon with which to attack one of the people involved in the triangle:

E., aged six, child of a divorcee, is the product of a common-law union which split up. He was referred for severe destructive acting-out behaviour.

His mother asserts that neighbors and school blame him for things 'he has not done.' Her main reason for the Clinic visits were to try to enlist the worker's help 'to put people in their place.'

The patient's play consisted of a little boy throwing a man out of bed and then pushing him out of the doll house window.

Presently, once again, mother is living common-law with another, an apparently rather violent man, whom the boy is supposed to call 'dad.'

When mother found that the worker would not go and blame the school or 'put the neighbors in their place,' she discontinued her own and the child's attendance, stating 'anyway you won't help me with these people.'

A young child, because of his mere superficial ability to express

feelings in words, and their emotions hence being bottled up and rather fierce, to what extent is it wise to release same in a session, at the risk that the child cannot contain same until next week's?

### Reality vs Fantasy

Since the young patient's sense of reality is precarious, i.e. there is a very thin line between reality adjustment and fantasy, in how far can we, as child therapists, remain the 'projection screen,' i.e. remain non-committal, and how far must we always remain Therapist cum Educator — at the risk of some repression — so as to strengthen the child's sense of reality?

A., aged three, had a throatache. 'My throat aches me.' "You have a throatache" he could not accept and it resulted in a battle between mother and youngster.

Playing it out by means of a cardboard-roll and sandpaper, it became clear that he felt his throat had become malevolent, and he hoped that by some magic of mine, I could make his throat 'behave.' Given, in simple terms, a medical explanation, he countered it with 'Why should I have that hurt when other kids don't?' 'It isn't fair;' in short, an age-old human problem in nursery-form.

Young children's ideas of right and wrong may differ markedly from that of the adult's.

M., aged four was caught stealing \$0.50 from a playmate, although M. has the same amount of pocket-money as the latter and has an excellent relationship with her parents and classmates.

Her parents were very upset, particularly so since the more they asked her for a reason, the more

reticent and 'mulish' she became.

By means of a purse and money, the worker playing the part of the playmate, it was possible to establish that the latter's allowance was in nickels, whereas M's was in quarters. M., intensely 'loyal' to her father, could not bear the thought that the other father 'had more money,' i.e. in her mind, was more powerful than her own. Therefore, according to her brand of loyalty, she had to 'take care of father.'

If the adults had continued accusing her of stealing, i.e. merely taking the reality factor into account, it would have left a permanent scar in her.

Only once the emotional conflict had been brought to the surface and cleared up, was she ready to accept a reality explanation.

The real pre-delinquent and delinquent child is amongst the most depressing problems. Aware of the acute shortage of vacancies in children's residences, is it practical to continue treating a non-neurotic patient of normal intelligence, a psychopathic youngster on an ambulatory basis, when knowing full well, that this can only — at best — stem the worst acting out, but not fundamentally help the child who really needs a closed setting, or are we to advise the parents to seek help via the Family Court?

P., aged ten, is a Canadian Indian, adopted at six weeks, has been for years and is consistently stealing valuable articles from shops and money from any unguarded purse. It has gone up as high as \$50.00 per haul. The school is seri-

ously considering expulsion. He spends the stolen money on candy and slot machines, or keeps the goods stolen, never sharing his ill-gotten gains.

Both parents work and are well-meaning but rather passive people. Paul denies everything until faced with irrefutable evidence, after which he shows no remorse. Of normal intelligence, he is an affectionless youngster.

The parents live their lives in constant dread as to what he will do next.

P. does not steal out of a game of 'cops and robbers,' i.e. dare-devildom, nor could a neurotic syndrome be found.

What are our criteria for stopping treatment? Is it, in the main, only alleviation of symptoms or is it, rather, freeing a child from neurosis?

With long waiting-lists, are we to content ourselves with just being an emergency-service?

### **Reaching the Problem Child**

Another concern to the writer is the fact that aggressive and hyperactive children tend to be referred much more frequently and urgently than the phobic, depressed or inhibited child, or the child who is 'too good to be true,' all this because 'they don't give any "real" trouble.'

In play, these children's immense suffering comes to the surface, yet often they are being overlooked by schools and referral agencies. Are we to go out into the community and actively seek out these children, or, overworked already as we are, just cope as best we can, with whatever child is referred to us?

Because the child is still living with both parents, a true 'transference' in Playpsychotherapy can never be fully established. The best one can do is to try and focus the child's love and hate onto the therapist.

This results in the fact that at one moment the worker is considered an angel, and the next, the devil incarnate.

This wild onstorm of emotions is hard to bear for the therapist, unless the latter has undergone an analysis. Every child therapist not only was once a child, but has also within the worker's own makeup, maintained some

childlike qualities. Thus the therapist is deeply involved as a person and constantly has to guard against personal aspects intruding in the treatment and clouding the picture.

Additionally, after many years of experience as a child therapist, there isn't a deep human problem that does not appear in the Playroom because the child runs through the whole gamut of humanity's emotional-ethical development. Thus in all humility, this writer concludes: 'Here, but for the Grace of God, go I' and "The world is but a stage, the play is the thing."

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