PARTICULARITIES OF CHILD PSYCHOTHERAPY

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ABSTRACT. A psychotherapeutic approach usually depends on countless factors, related not only to the chosen methodology or the dimensions of the client's pathology, but also to a much larger context. Especially when it comes to considering the presence of a child in therapy, with or without his parents, the therapeutic work is different from the one regarding adults due to the fact that the approach needs to be suitable for the child's specific stage of development. The methods and techniques used are meant to indirectly access information because the use of verbal means of communication, which is mostly preferred in adult psychotherapy, is almost pointless when considering young children. Beside these aspects related to the therapeutic process, it must be taken into account the fact that the client's personality is not fully developed and some sorts of distortions which can come along the way, either due to the therapeutic failure or to the client's resistance, can bring about an eventual pathology.

This paperwork tries to define the dimensions of child psychotherapy from the ones of adult psychotherapy, referring to specific factors which can disrupt or improve the course of therapy, and also to the impediments that can arise in the therapeutic relationship.

KEYWORDS: child, behavioural problems, child psychotherapy, resistance, therapeutic relationship

1. INTRODUCTION

There had probably always been a percentage of children with behavioural or emotional problems, but they were considered age-specific disorders and were not assessed as medical cases. Consequently, some behavioural disorders were largely seen as moral issues, thus receiving a physical punishment and rejection from the group. Cognitive deficiencies such as low intelligence, inability to maintain attention, or mnesic problems, had also led to stigmatization and exclusion from the social or familiar circle.

Few medical papers related to children, which had been written prior to the 19th century, focused mainly on somatisation issues, such as sleep disruptions manifested by sudden awakening, self-violence in the oniric state, epileptic seizures, or violent episodes related to rivalry between brothers. The predominant outlook that most psychiatric disorders did not occur before puberty was demonstrated by the fact that there were no children in asylums (Parry-Jones, 1989).

In the nineteenth century, together with the publication of Jean Piaget's theory regarding the stages of cognitive development in 1936, the medical world began to take into account the fact that children also needed special attention and that a distinction should be made between how to approach an adult and a child in therapy (Piaget, Inhelder, 1968). Maudsley wrote in 1895 "The Pathology of the Mind", where he devoted a chapter to childhood madness, describing some affections such as panic attack and infantile anxiety (Maudsley, 1895). The acceptance of human development at that time sustained the development was not complete until around the age of 25, indicating that psychological pathology might have a reduced incidence until young adulthood. For example, Tuke (1892) specified that the worst period coinciding with the occurrence of mental illness was thought to be between 21 and 25 years, meaning immediately after adolescence, a stage which, according to medical statistics of that time, was not associated with a representative frequency of mental disorders (Tuke, 1892).

Anna Freud showed that the relationship between child and therapist was different from the relationship developed at the family level. Although parents represented the most important persons of the child's life, the therapist could not just pretend to be the child's friend and thus it was inevitable to be seen as a figure of authority. Anna Freud's important discovery was that the positive way to deal with this "transferrential problem" implied that the therapist adopted the attitude of a thoughtful adult, not of a playmate or of an alternate parent. Even if transfer could be blocked by certain contexts, for example during the process of projecting the parental figure upon the therapist (which needed to be processed in a veiled fashion), Anna Freud's approach worked in most cases (Freud, 2002).

However, working with children in psychotherapy cannot be considered easy at all because their symbolic skills are not as advanced as those of adults, and both the youngest children and adolescents may have problems with the narrative expression of their emotions and feelings, which also implies they do not bury their problems under complex symbols because everything is considered to take place in the "here and now" (Freud, 2002). This leads to drawing the conclusion that children's problems are closer to the conscious surface and tend to be expressed directly, from behavioural and emotional points of view.

2. DIFFERENCES BETWEEN CHILD AND ADULT PSYCHOTHERAPY APPROACHES

Delgado and Songer mention that the internalization of objects during early childhood does not imply only the imitation of their characteristics; in fact the internalized aspects are actually filtered by the desires and needs of the child (Delgado and Songer, 2009). In other words, internalized objects are being given some individualized meanings, which are adapted and modulated through the prism of active awareness, these contents not always being identical representations of the real object. Melanie Klein wrote in 1932 that since birth, in the first years of life the child has a primitive fear, referring to that period as the "paranoid position", in which the internalized representations of significant ones around the child are experienced as partial objects that are perceived through the polarity of "good or bad". Thus the presence of the breast is integrated as having a positive connotation, the negative connotation being represented by its absence. Klein also exemplifies that a child with anxious tendencies, being in the "paranoid position", can internalize an emotionally available parent as "not present". In the early stages of his development, the child maintains the separation between Self and objects in order to avoid traumatic recognition of the existence of aggressive aspects found in others or within himself. A second perspective that has had special implications in later infantile psychopathology is represented by the so-called "healthy depressive position" that succeeds the paranoid one and implies that the child learns to integrate the reflection of a reality that contains people who can simultaneously have both "good" and "bad" sides (Klein, 2010).

Many of the children requesting a therapist's help, either directly or through a family member, have been subjected to traumatic experiences. Ken Redgrave (2000) identifies the most representative situations: affective repulsion from parents, mostly from the mother, physical cruelty, sexual abuse, disappointing behaviour of the significant ones, mental confusion regarding the children's identity and the reason they are rejected or abused. Other experiences that can also be added to the list include traumas caused by conflicts between parents, psychological games or warfare games. Many of the children who have these traumas believe their parents are "good", but yet they attribute a certain amount of anger to them and, because of what emerges from their unconscious, children tend to feel an irrational guilt. As traumatic events have been suppressed, one of the first goals of therapy is the work done in order to become aware of how things really work. However, the approach is difficult because children prefer to project their feelings onto others and consider only the current events as disturbing, rather than recognizing the implications of little childhood experiences and the negative role played by parents (Redgrave, 2000). The representation of the significant parent is divided into a conflicting bipolarity: on the one hand, it is the image of the idealized parent which has always been the basis of the formation of the Self, and the image of the abusive parent which disintegrates the Self.

The fact that the personality of the child is less developed than that of the adult involves a different therapeutic approach. His defence mechanisms have not been grounded yet, but brain structures are more flexible and responsive to therapy, and the child's personality is in a period of fast development, all these factors generating greater potential for change. The negative side is that a child is more vulnerable and can generate certain normal emotional and behavioural responses as a result of the unformed personality nature, but this represents a major challenge for the therapy. Prout recommends that the therapist should also be more flexible and open to metaphoric play, anticipating and integrating in a wider context the sudden emotional and behavioural changes during the therapeutic process. The plasticity of the child's personality represents a great advantage in developing and internalizing a preventive model that eliminates disturbing patterns before the process of personality crystallization (Prout, Brown, 2007).

In addition to these differences in personality, there are also those concerning the level of verbal and linguistic development, which are more precarious in the case of children. They may have insurmountable difficulties in understanding abstract concepts, which is normal in their stage of cognitive development, but they can also have difficulties in expressing thoughts and emotions. Prout mentions that one of the main reasons why gameplay was used as a means of therapy is precisely this limitation in communication,

the gameplay and other nonverbal techniques reducing the anxiety of the child which has been caused by the inability to find the correct verbal description. Therefore, the therapeutic technique should be adapted to the appropriate level of development and alternative ways of non-verbal expression should be investigated in order to be used with verbal interactions. A suggestion would be for the psychotherapist to learn the verbal mediators regarding certain emotional experiences, but this process presents the inconvenience of involving long-term therapy (Prout, Brown, 2007).

The approach on the cognitive axis attempts to change cognitive deficits and distortions, focusing on defining the problem, generating alternative solutions and anticipating the consequences. Interventions usually involve role-play, homework, and the use and formation of specific abilities that will change those cognitive distortions. Psychosocial treatment is based on a careful assessment of the stage of child development, which will define the approach line and the corresponding therapeutic methodology. According to Rappaport (2004), when considering the context of mental development, the therapist tries to promote the development of new skills and to encourage the adoption of new methods of coping that will take the place of maladaptive behaviours. Techniques themselves fully require the therapist's flexibility and creativity, making him juggle through a great deal of ideations and whims. Generally, the therapy focuses on the current functioning of the child, with an emphasis on the events and emotions that take place in the "here and now", underlining the renegotiation of the child-parent relationship. Adolescents often do not recognize their need for help in overcoming a situation and may find that the difficulties are derived from the unrealistic answers of teachers or parents. On the other hand, the cognitive, affective and emotional flexibility of children makes them more receptive than adolescents when it comes to building a trustful relationship with a therapist (Rappaport, Thomas, 2004).

Parents are the primary source of information regarding child functioning, and knowing the child's behaviour and emotional response over time and in different situations plays a key role in the therapeutic process. Emotional and behavioural problems often reflect a deviation from the proper way of acting and reacting in certain circumstances, such as losing interest in playful activities or social isolation. It can be stated that parents, through their informative function, contribute to the process of change, but this raises additional issues such as whether the difficulties in adjusting and functioning of children are related to their parents' psychopathology, or are derived from conjugal problems.

Parents with psychopathological disorders or tendencies can assess their children as having deviant behaviour because they associate it to their own cognitions, and even when there are some increased dimensions of personality, they are eclipsed by the parental dysfunction. Consequently, improving the condition of the child at the end of therapy may reflect current changes and the specific outcome of therapy, but may also indicate a reduction in parental pathology. At the same time, regardless of the methodology involved or the duration of therapy, there can be seen little improvement in the child's condition or even an increase in symptoms when the stressful situations in the family, parental psychopathology or environmental stressors continue or increase their intensity.

Consequently, the child is influenced by the parental psychological condition, but the process is reciprocal at the same time, the parents' reaction to children's psychotherapy being able to trigger feelings of guilt. The psychotherapist can be seen as an expert who can provide a better alternative to child care, but this investment made by the parent after recognizing his or her inability to support the child can quickly move from idealism to denigration. All of these have important implications in the way the psychotherapist sets his therapeutic plan, but the success or failure of the treatment cannot be assessed only as a result of the effects of therapy because it implies much wider connotations that reflect a multidimensional framework composed of family, colleagues, teachers, friends, etc. Therefore, child psychopathology may have internal causes, but at the same time it may be an adaptive response to environmental pressures, or may indicate just another facade of parental psychopathology (Godfried, 2003).

The specificity of complex traumatic experiences is that they are evoked differently by adults and children, the latter having difficulties in the process of integrating the event into their mnesic system, because the trauma is not stored as a verbal memory that can be coherently recovered, reported and processed, as it is in the case of adults. Thus, when it comes to children, the traumatic events emerge from the unconscious in the form of disorganized fragments, with a great sensory and emotional impact. Symptoms related to evoking the experience are extremely vivid and painful, but they are difficult to correlate with current events. Consequently, children depend on parents or other significant people in their lives to create a coherent biographical narrative frame, because they do not have the

cognitive ability to tell their own lives. Unfortunately, the story told by others is filtered by subjective contexts and here the therapist takes the role of "the most trustworthy person in the child's life", a quality derived from his objectivity and professional neutrality. Nevertheless, many parents report having an increased fear that the relationship between the therapist and the child can become too close and manifested by the dependence on therapy, but this is a normal process preceding independence.

A distinctive aspect in child psychotherapy is the one regarding the dissociation between the child's internal world, populated by fragmented events which are hard to describe and are only partially integrated in their Self, and the world of daily experiences consisting of normal situations or social relationships. The therapeutic difficulty consists in the fact that, in most cases, simple events can be distortedly interpreted by the child, being observed in the light of his own conceptions of the world and in correlation with the stages of his cognitive development. Thus, daily experience becomes an essential source of knowledge of the child's dynamics, Wachtel stressing in this context that the importance of emotional exchange between the patient and the therapist is fundamental to therapy, but its clinical value is reduced when the events and experiences that constitute the patient's life outside the therapeutic setting, are not integrated (Wachtel, 2011). The meaning or implications of what is transferred to the therapeutic process cannot be properly understood without understanding the reality of what is happening in the child's daily life, a reality that is often difficult to decipher from the patient's speech.

Another difference in child therapy is that children tend to quit prematurely, with specialty studies claiming that a significant percentage interrupts therapy after 2-3 sessions (Wierzbicki & Pekarik, 1993). The authors of the study point out that the main factor is the lack of intrinsic motivation, and the fact that it is often parents who persuade the child to participate in the therapeutic sessions is not very helpful. On the one hand, the fight for persuasion is tedious and the parent or parents need a great deal of patience and energy, a situation that is becoming more and more stressful, especially if the child has to be determined to participate in therapy 2-3 times per week, in his free time that he would prefer spending in a much more enjoyable way. On the other hand, there is the opposite pole, when one of the parents is against psychotherapeutic treatment, the conflict that emerges within the family having the power to turn therapy into a source of tension. Other causes that may contribute to premature termination of therapy include the economic factor, environmental pressures and the severity of the child's dysfunction (aggressiveness, antisocial behaviour, etc.).

Keeping children in therapy remains a challenging situation and differs from those in the case of adults, the therapist having to take into account various contextual factors such as family environment, school environment, the stress generated by the therapeutic process, the prevalence of intrinsic motivation, etc.

The difficulties in child psychotherapy are also represented by identifying the optimal methodology applied in the therapeutic process, because the factors that contribute to or maintain the behaviour deviation or distorted perception of events need to be very well understood, not only from the patient's discourse but also by integrating external information from family, friends and teachers. Thus, identifying an effective approach is not just a matter of applying a method and checking if this intervention reduces or eliminates the existing problems, and if the outcome is negative, something else is being tried. There should also be considered obstacles that might interfere with the intervention, such as how the child is treated in the family, at school or in the circle of friends, and whether he integrates and recognizes these influences.

3. SPECIFICITY OF THE THERAPEUTIC RELATIONSHIP IN CHILD PSYCHOTHERAPY

George Kelly sustained in 1955 that the therapeutic relationship in child psychotherapy should start from understanding how the child gives significance to the environment and environmental objects, but also how they are connected with wider construct clusters of his awareness. Through the assessment and diagnosis that precede the therapeutic process, the specialist identifies the cluster of individual mental constructs, thus gaining the perspective of the child confronting himself and the world. This primary diagnosis requires distinct approaches that are specific to Piaget's theory of development, using both verbal and non-verbal techniques. Kelly states that the individual uses constructs to form models by which he internally perceives the new events he thinks he can repeat in the real world, thus anticipating them. The way the child builds these models depends on how aware he is of external events, which in turn depends on the models he has previously built and integrated (Kelly, 1969).

As in most psychotherapeutic directions that emphasize that non-verbal techniques (using play or body movement) are the most useful when working

with children, Kelly also has identified preverbal constructs that begin when linguistic interpretation is precarious, that is in early childhood, later perpetuating only as feelings because no verbal representation has been developed for these constructs. Therefore, accessing, interpreting and processing these feelings must be related to the awareness of the fact that their basis involves an archaic form of language. Significant in this respect is how children anticipate the outcome of their own actions according to how their cluster of constructs change, reflecting the individual processes of understanding the intra- and extra-psychic reality (Kelly, 1969).

Thus, changes that occur can affect the development of the Self, the conceptualization of children's psychological problems focusing on their feelings of identity and belonging and also on the reality of the world they live in (Hardison, Neimeyer, 2012).

However, basic constructs are idiosyncratic and harder to change, and it is preferable to avoid invalidating them before the development stage offers other alternatives. Kelly sees the behavioural manifestation of children as being experimental and not reactive, revealing indications of how they build their Self and integrate everyday experiences. With regard to the above concept, it supports a therapeutic system based on the diagnostic dimensions of construct and transition, which Kelly calls "transient diagnosis", meaning that the pathology is conceptualized according to behaviours and the meanings that children assign to events (Kelly, 1969). Following this approach, the therapist captures the real experience of children, their own Self-building processes, and formulates hypotheses based on these understandings. Within the therapeutic relationship, constructivist psychotherapy mentions a method of establishing the therapeutic alliance by mobilizing and implementing specific techniques in order to understand children's constructs, as well as communicating through the process of building and rebuilding the problems that bring the client into therapy.

In addition to other specific characteristics of working with children, that have been described above (contact by play, body involvement, etc.), the presence of parents is one of the parameters that can interfere with the therapeutic process, but children's psychotherapy can only be done if there is an agreement with the parent or the legal representatives. In other words, since the beginning of the therapy, the presence of parents influences the therapist's countertransference. Jaqueline Godfried believes that the conscious and unconscious attitude of the parents determines the possibility of a positive therapeutic resolution, and assessing the way the unconscious resistance of parents can later influence treatment is a major difficulty. The question is how parents adapt to the child's changes and questions arising from the therapeutic sessions, but also how the child's therapy influences the pathology of their parents (Godfried, 2003).

As a result, in understanding mental functioning, the presence of parents creates the therapist's confrontation with the constant integration of the mutual relationship between individual knowledge and the concrete experience of the individual. Godfried theorizes that psychological development must take into account the influence of the external world on the individual, but also the influence of the intrapsychic organization. This concept is reflected in two directions: one indicates the theory of neuroses which transfers the cause of symptoms to the outside, and the theory of intrapsychic fantasy related to psychosexuality. In therapy, the presence of parents constantly updates the reality of environmental factors, thus risking a biased intrapsychic understanding of the meanings related to the child's internal and external reality. Thus, the parental presence introduces parameters that can interrupt, block or distort therapy on the one hand, through intrusions at the therapeutic setting level and on the other hand through conscious and unconscious interactions between the parents and the therapist. The consequences of this thing can be manifested in the therapist's symbolisation roles, distorting the interpretive qualities of the therapist and impairing its ability to think objectively and neutrally. Godfried exemplifies in this case the appearance of incongruent behaviour or inappropriate emotional responses which are the expression of some weaknesses in the therapist's capacity to mentally integrate the informational flow to which he is subjected, weaknesses expressed by disrupting the containment ability (Godfried, 2003).

Another way to strengthen the therapeutic relationship in infant psychotherapy is to offer alternatives and to make personal choices, which is another way of strengthening the Ego. Oaklander (1997) specifies that many children avoid making even the most insignificant choices and do not resort to the decision-making capacity they possess because of the fear of making the wrong choice. It is therefore preferable to offer as many options as possible in the therapy, starting with the least significant, such as the choice of where to sit (on the floor, on the chair or on the couch), the writing tool, or the colour of the pencils. Subsequently, more complicated choices are

made, which relate to what is wanted to be discussed in the therapeutic session or the homework that is preferred. The ability to choose and the development of a sense of decision-making capacity are ways that reinforce the development of the Self, helping the child to develop a strong sense of Self, and according to Oaklander, it is a prerequisite for helping him to express repressed emotions that in turn will evoke the spontaneous emotional expression (Oaklander, 1997).
However, there may be many barriers in the therapeutic relationship because most children tend to adopt certain behavioural reactions as a way of coping, but these are considered as resistances in psychotherapy. Because it is difficult for a child to identify the cause that has led to the appearance of this coping mechanism, it overcompensates through more and more intense behaviours, but ultimately the effort will fail. For example, a child will show a high dose of aggression in response to punitive parenting, will hit other children, and will try to force others by violence as a preventive measure of not being injured. In therapy he will have difficulties in forming a relationship because he will always have the impression that at some point the therapist will hit him and, in order to confirm his faith, he will do his best to adopt a defiant attitude, often aggressive, trying to provoke a violent reaction. However, giving the child alternatives and the possibility of choice, he will realize that the world is not totally aggressive and rigid, as he has experienced in the family environment. As he develops a stronger self-esteem, based on his own choices which do not imply a punishment-reward system, but neutral alternatives, the maladaptative behaviour is replaced by more effective ways to get in touch with the world.
Most children manifest some form of resistance, although perhaps not at the extent of the one that has been previously described. If there is no resistance, Violet Oaklander (1997) claims that the child's Self is so fragile, showing extreme docility in order to survive. In this case, the therapeutic process will focus first on the techniques of strengthening the Ego until a certain resistance emerges, because at its base, resistance is a child's ally and the mere fact that the therapist accepts a small dose of resistance from the child helps him take the risk of doing something new. As the child begins to feel safe, he will abandon this resistance for a while until he discovers more than he can express, and then the resistance reappears. In this way, the resistance is at the same time balanced and limiting because the child cannot be forced to exceed his abilities. Resistance is also a sign that in the unconscious there is a material that needs to be explored and put into practice, and the child seems to know, at a certain level of intuition, when he can process and integrate this material. In other words, resistance is a manifestation of energy as well as an indication of the child's level of contact, and as the child engages in the therapeutic alliance, resistance is an indication of therapeutic progress (Oaklander, 1997).

4. CONCLUSIONS

Now, more than ever, it is necessary to pay special attention to infant psychopathology because psychiatric disorders in children correlate with some impressive physiological, affective and cognitive manifestations having a multidimensional impact on individuals, their families, the educational system, and last but not least, on society.
An optimal therapy that reflects this broad approach usually requires practitioners in the fields of medicine and psychotherapy working together because in spite of the current success, child psychiatry and psychotherapy undergo dramatic changes, resulting in new opportunities and challenges, primarily due to easy access to information and globalization. It would seem somewhat paradoxical that globalization may have negative valences, because from the outside it would be a positive context that could integrate distinct aspects of East and West practices. Nevertheless, unjustified homogenization of methods leads to the loss of important cultural nuances, which could lead to more effective treatment within specific populations.
In child psychotherapy, the child's problems need to be addressed directly, but the challenge is how this is done because, as mentioned above, factors that influence the child's condition are not all internal factors. Identifying and changing disruptive factors, both internal and external ones, are major challenges, and keeping a constant relationship with the family is essential, whether or not there are issues in the existing marriage.

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