How it Feels to be You

Objects, Play and Child Psychotherapy

Tamsin Cottis

KARNAC

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A therapist spends a lot of time working solo, but is not at all alone.

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About the author

Tamsin Cottis is a UKCP-registered child psychotherapist. She is a co-founder and former assistant director of Respond, the UK's leading provider of psychotherapy to children and adults with learning disabilities. Formerly consultant clinical supervisor at Respond and a teacher at the Bowlby Centre, she works as a child psychotherapist and clinical supervisor in London prim-ary schools and in private practice. Tamsin is a founder member of the Institute of Psychotherapy and Disability and a member of the International Association for Forensic Psychotherapy. She has presented her work to a range of national and international audiences and has written widely for books and professional journals. Tamsin is a published poet and prizewinning author of short stories.

Introduction

When a child arrives at the therapy room door, they may not know what therapy is, how it helps or what it will involve. They may have made an active choice to be there, or be reluctant to attend. If the session is taking place within a school, they could be pleased to be out of the classroom. Their feelings may be of excitement, resentment, relief, fear or any combination of these. They will be aged anywhere between 3 and 18.

We probably won't have met each other before, but I will have been told something about the child or young person by an adult who knows them – most likely a parent or teacher or other staff member such as the Special Education Needs Coordinator (SENCO). I will have asked that adult some questions, and had a conversation about their understanding of the child's difficulties. I will have learned something of the child's life experience up to this point (see Appendix 1 for a more extensive list of questions to consider during the assessment process.

I open the therapy room door with an open mind. I don't yet know what a child themself would say about their difficulties, or how much of a problem they feel they have. I don't know what they remember about their life experiences, and what they understand about how those experiences have affected them. The question in my mind as I greet a child is: 'How does it feel to be you?' This question will guide me through all the sessions we will share. The answers may be revealed by what the child tells me. But the things we *do* together, and how we *are* together as the sessions unfold, will be my main sources of insight. Often, what we do in therapy as child therapists does not look or feel like what we think therapy is or should be. It can be a mysterious process.

This book explores what it is that happens in child therapy and how it helps. Each chapter has a theme, but its subject is a

child rather than a condition. The book tells individual stories of therapy, with a child at the centre of that story. As well as coming to therapy with a range of difficulties, the children I work with come from many different backgrounds and family situations: one- or two-parent homes; blended families where not all the children have the same parents; where parents are the same sex or different; and homes where several generations of the same family live together. I have worked with children from some of the most affluent homes in the country, and some of the poorest, and children from a wide range of national, racial, religious and cultural backgrounds. It has not been possible to write about every disorder, or every family configuration, and that has not been my aim. But I hope that the book reflects some of the extraordinary diversity of children's lives and experiences in the UK today.

In each chapter I have presented a child who is partly the creation of my imagination and partly formed by the sensibilities of a number of children who share aspects of these stories. The activities and dialogue are drawn from a combination of imagination and experience. I have changed identifying details and context while remaining true to the scope and content of actual work. If this has not been possible, specific permission to use material has been given.

All the activities, interventions, games or conversations that you will read about here take place in the service of a therapeutic relationship. It is this therapeutic relationship that is the most important aspect of any help I am able to offer.

The book does not set out the different schools of child therapy that are out there or seek to assess relative outcomes in a quantitative sense. That work and data are important, but on these pages I'm going to describe what I, as a child psychotherapist, do in the room and why. I am an integrative child psychotherapist. As such, my work with children draws on a range of psychotherapy theories. I am seeking to support a young person to live comfortably in their own skin and be the fullest version of themselves that they can be – emotionally, relationally, socially, cognitively and physically. In doing this, I am weaving

together a range of connected and complementary theories and approaches. The scope of this book does not allow for detailed exploration of these, but I have briefly outlined here the key ideas that inform my practice with children. I include references for readers who wish to find out more.

Attachment Theory

Attachment Theory originated in the 1950s through the work of John Bowlby (1953, 1969, 1973) and has been developed by many others since then (Ainsworth *et al.* 1978, Brisch 2002, Geddes 2006, Holmes 1993, Main *et al.* 1985, Sroufe *et al.* 2005). Bowlby hypothesized that the extreme behaviours that infants engage in to avoid separation from a parent or when reconnecting with a physically separated parent – such as crying, screaming and clinging – were evolutionary mechanisms. He suggested that these attachment behaviours serve a biological purpose as well as an emotional one: we need our carers in order to survive infancy, so we adapt our behaviour to make sure we get what we need. Attachment Theory studies over the past 70 or so years have demonstrated that an individual's attachment behaviour – that is, how one relates to, and feels and expresses, one's connection to others – can make up a wider behavioural system. These systems or styles have observable characteristics and have been identified as secure, insecure avoidant, insecure ambivalent and insecure disorganized attachment styles. Though developed in childhood, they can also be seen to carry on into our adult relationships (George *et al.* 1985). They have also been shown, through therapy and/or other healing relationships, to be subject to change (Powell *et al.* 2007, Siegel 2020). Siegel has identified an additional attachment style, earned secure attachment, which occurs when a person has had the opportunity, through reparative relational experiences, including therapy, to experience and respond to attachment feelings in new ways.

Object Relations

Like Attachment Theory, Object Relations theory – pioneered in the first half of the twentieth century by child psychoanalyst Melanie Klein – also puts the early infant/primary carer relationship at the centre of the child's experience of growing and developing in the world. The primary carer is seen as the Object for the child, as the infant grows through babyhood to have a sense of themselves as separate from, but existing in relation to, others. The nature and quality of the care a child receives profoundly influence their sense of what being in a relationship feels like. If it is difficult, or unpredictable, a child's capacity to relate, get help from, feel supported by and develop a capacity for trust will be adversely affected. A child gradually learns, through their relationship experiences with their main carers, that the Object can be both good and bad, and both states of relating and feeling are inevitable, survivable and will pass. An internalized experience of this helps the child, as they develop, to withstand the pressure of strong feelings, seek support if in distress and retain a sense that things can and will get better.

The robust enough carer is able to be a 'container' for the strong and difficult feelings of the child, and to support the child in managing these feelings without becoming overwhelmed. This process of containment is a key aspect of the work of Donald Winnicott (1953) and Wilfred Bion (1959).

Inevitably, ruptures occur in a relationship – minor or major. But if the primary carer takes steps to repair the rupture, and make it right with the child again, the child gradually learns that someone cares enough about their distress to make them feel better. The child learns to have a realistic expectation of this occurring again in future. This gives them confidence to go out in the world despite risks and uncertainty. The development of a secure attachment also occurs through reliable and consistent enough parenting, and the repairing of ruptures, when they occur.

Relational early experiences with primary carers have a long-term impact on how children make sense of themselves and others as they grow. Attachment Theory and Object Relations are not about achieving perfection in parenting or ideal parent–child relationships, because there is no such thing. They are, in Winnicott's (1951) phrase, about 'good enough' parenting.

How an individual child's personality and internal world interacts with their experiences, and what arises in terms of behaviour, emotional state and a capacity to repair the damage of early life adversity, is in my experience infinitely variable. It is not straightforward or predictable that a particular experience will lead to a particular difficulty for a child in the future. External life circumstances, particularly the emotional and social impact of poverty, seem to be highly significant, as well (Scottish Adverse Childhood Experiences Hub 2017).

As therapists, we seek to provide a positive attachment experience for the child, which will be characterized by reliability, trustworthiness, attunement, empathy and the containment of very difficult feelings that may overwhelm the child. The thera-pist will also seek to be sensitive to relational ruptures when they occur, and make thoughtful, considered efforts to repair them.

Neuroscience, affect regulation and the impact of relational trauma

Our developing understanding of neuroscience and brain development, especially Porges' (2011) polyvagal theory and the work of Allan Schore (1994, 2003), indicates that positive, reliable relationships (where the child has an experience of being attuned to and empathized with) facilitate optimal development of the brain. Neuroscience shows us that too much fear and stress in infancy can impact on how the brain's neural pathways are laid down for a child. (In the first year of life, brain size increases by 70 per cent.) Traumatic experiences can

have a long-term impact on how a child both relates to others and develops a capacity to manage strong feelings that are experienced in the body, mind and nervous system of the child. How children manage their feelings (that is, affect regulation) plays a key part in the therapy process. Neuroscience works in concert with Attachment Theory and Object Relations, and seems to show that optimal brain development and a capacity for affect regulation are aided by secure attachment and good-enough care from the object over time. The relational theorists such as Bowlby and Klein came first, but it now seems there is scientific evidence to back up many of their observations and theoretical ideas.

The importance of objects

This book highlights the importance of objects in child therapy. It illustrates how they are integral to the building and sustaining of the relationship between therapist and child, and can be employed to effect relational change. Each of the chapters in this book contain descriptions of objects that became significant to a child and therefore to me, and were crucial in our work together. To a child therapist, a toy is hardly ever *just* a toy. It will be playable with in an ordinary way, but will also have the potential to support the expression and experiencing of feelings, and reflection *on* those feelings.

In his work from the 1940s onwards, paediatrician and child psychoanalyst Donald Winnicott observed how babies and young children had objects (soft toys, or pieces of blanket, for example) to help offer them comfort (Winnicott 1951). He saw how these objects helped the child to manage transitions or separations in particular, and viewed the object as somehow 'standing in' for the parent. He also noted how the child's attachment to the object or comforter was deeply supported by the parent. Objects, and the transitional phenomena that I am calling here *object games* (that is, games created by the

child, played repeatedly and liable to further development, and the details of which are mutually understood and shared by therapist and child), play a crucial part in supporting a child in therapy, including through the changes that may be occurring internally and externally through the therapy process itself. The objects often have a sensory dimension, too. They have to 'feel right' to the child – reflecting the intense physicality of the infant experience.

Winnicott called these items transitional objects and said they existed in a border territory between conscious and unconscious experience. He described how the object can become a carrier for the essence of a relationship itself. In play-based integrative child psychotherapy, particular objects assume great significance and are also intensely relational. The meaning of a transitional object is understood fully only by the child and people who are important to the object owner, usually the parent. The therapist, like a parent, fully recognizes the object's importance, respecting it, searching high and low if it is lost, knowing that an apparent exact replica replacement probably will not satisfy. In doing so, the therapist allies themselves with the child, who has intense feelings of need for the object and experiences it as having special powers to comfort and reassure.

The coming-into-being of significant objects in integrative child therapy also reflects something of the intrinsic creativity and 'self- building' potential of the therapeutic process itself. The child chooses the object and has the experience, perhaps for the first time, of feeling 'I did that!'. Winnicott says, 'No human being is free from the strain of relating inner and outer reality … relief from this strain is provided by an intermediate area of experience which is not challenged' (1951: 240). In my experience, for a child who is struggling to find their way in their world, play-based therapy in general, and some objects in particular, can help to provide this relief.

The importance of play and creativity

Our capacity for creativity is intrinsic to our humanity (Winnicott 1951). Play allows for the creation by a young person of something that wasn't there before, something that speaks 'of' the person or has their unique 'voice'. Creative play, when shared and appreciated by another person, plays a crucial part in building and strengthening a sense of self. A robust and resilient sense of oneself as loved and lovable is essential to the good self-esteem that helps a child chart a steady, positive course through their development. Play in therapy provides myriad opportunities for a child to externalize their lived experiences and to express and reflect on their feelings. In his PACE model, psychologist and therapist Dan Hughes (2007) sets out the centrality of Playfulness, Acceptance, Curiosity and Empathy in his attachment-based approach. The model demonstrates the way in which theory and practice can integrate in support of therapy for a child.

Play also allows for communication through metaphor – using story, objects or games. Talking directly about difficult feelings or painful experiences can be hard for many people, but accessing those feelings and bringing them into a shared space with an empathetic other is another critical part of relational development. Using metaphor can help make this possible. The accounts in this book will illustrate some of the many ways in which play in therapy can facilitate this.

Play with others provides opportunities for fun, and for reciprocal enjoyment (Alvarez 2012, Sunderland 2016). A child in emotional difficulty – perhaps living in very stressful circumstances – may come to therapy with a sense of themselves as 'a problem', and they and their family may be under great strain. Experiences of mutual joy and pleasure generate brain chemicals such as serotonin and dopamine, which feel good to the child and are shown to benefit brain development. Play-based relational therapy, which is often filled with activities that occur at the direction of the child, offers many and various opportunities for this.

Working in the transference

As a therapist I'll be paying attention at all times to my own feelings – that is to say, I'll be working in the transference. Transference is a psychotherapeutic concept which refers to the process whereby a child experiences the therapist, in the moment, as if they were someone else in their life, such as a parent, sibling, friend or teacher. For example, if a child is very controlling to me as we play, and I know they have a domineering older sister, I will understand that, in the moment, the child may be primarily expressing the way their sister makes them feel, that is to say, there is, in the moment, a 'sibling transference'. The countertransference is how that transference makes me feel, so I may be irritated or frustrated – which is how the child feels when they are with their sister. My understanding of the transference will impact on my responses, and I will need to be acutely alert to my own feelings, which may, initially at least, be derived from my unconscious. A very strong countertransference feeling may be the consequence of a projection whereby the child puts a feeling they would rather not experience into the therapist, so they can feel it instead.

Writing, thinking and talking about these processes – through my own notes and supervision – will help to bring these feelings into my conscious awareness and experience.

Working in partnership with others

Children, by definition, do not live independently. They need others to support them as they grow. If a child's carers and supporters can work together co-operatively and thoughtfully, the child will feel more contained, secure and positive. Therapy is a chance to work alongside other people who care about the child, so they may think collectively and collaboratively about what might be best for them (Blackman 2002, Dallos and Draper 2015). However, this approach can potentially challenge and test the boundaries of privacy and confidentiality, which are so

important in therapy. This issue is explored in the book.

In addition to my theoretical knowledge and experience in practice, I seek to be the most authentic version of myself that I can be. Through their life and training, a therapist has gone through a process of finding their 'therapist's voice', in the same way any artist or creative practitioner finds *their* 'voice' (Alvarez 2006). Although I am working to a theoretical model, and using approaches explained and sometimes devised by others, only *I* can produce this particular version of them. As therapy is an intersubjective process, predicated on the idea that people in a relationship affect one another, I recognize that I am subject to affective change and development, too. As a therapist, I have professional and ethical responsibilities. I have to be reflective, open and non-defensive. I need to take reasonably good care of myself, while also (inevitably) having an everyday life that is as liable to stress, strain and unforeseen events as anyone else's. I have to be able to experience vulnerability, uncertainty and failure as well as success, confidence, hopefulness and satisfaction. It will be hard to support a child in bearing difficult feelings if I can't bear them in myself. To this end, I will access good-quality support from other therapeutic practitioners through my own ongoing supervision, training, professional development and at times personal therapy.

Finally, I do not occupy a separate universe from my child clients. I bring my own prejudices, assumptions, privilege and lived experience into the room. I also need to be an active member of wider society, attuned to the impact of the political and social context of the child's life, including structural inequalities.

1

SAMINA

A game of Jenga

Beginnings

Samina was 8 when she was referred to me for therapy in school. A British Muslim girl of Pakistani heritage, she was the second child of four, with an older sister in the school, a sister in nursery and a baby brother at home. Samina was referred because her mother had reported that her husband, Samina's father, had been violent towards her at home. On several occasions, the police had been called to the home, and this had triggered Social Services involvement. Safeguarding procedures had been put in place, and Samina's mother had sought help from local agencies offering support to victims of domestic violence. She was working with social workers and other supporters to ensure her own and the children's safety as far as possible.

I was told that Samina in particular had been distressed by events. Her mother described her as uncharacteristically angry and oppositional at home, especially in her relationship with her older sister. The two fought a lot, including physically. Samina was described as a very bright girl, doing well academically, with no history of difficult behaviour in school.

In her first session, Samina seemed confident. She came with me happily from her class and told me that her mum and her teacher had told her I would be coming to see her.

'I saw you in my classroom last week,' she said, looking at me directly. (I had sat in for a while as an observer.) 'Also, I saw you on the street in your jacket. That jacket.' She pointed to my coat on the hook by the door. 'I saw you when I was coming to school!'

When the child comes in, I notice where their eye falls, how easily or not they approach me, the materials and the toys. I notice how tense or relaxed they are, how they hold themselves, how openly curious they are and how much permission they seek before acting. I take in as much as I can about how easily they look at me, speak to me or not, sit down and move across the room. In the first session, I have a couple of ideas as to what

we might do, unless the child's curiosity takes us somewhere else.

One thing I often use in the first session is the game Jenga. Most children will have come across it before, so it won't be alarming. It is not obviously childish: adults enjoy it, too. For a number of children, the two boxes of Jenga in my room (one of which also has questions handwritten on the bricks, such as 'What does your dream house look like?' 'What was your happiest day?' 'What was your earliest memory?' 'What is your best meal?') become an object of significance.

I could see straight away that Samina was alert and aware. I was pleased she was prepared for the session, and impressed by her keen powers of observation. I was also holding the thought that, if a child has experience of living in a violent home – where the mood of adults might switch from safe to dangerous very quickly – they are likely to be extremely vigilant. As will be explored in subsequent chapters, *if* if a child is living too much 'on tenterhooks' and so in a fight–flight–freeze-flop mode of hypervigilance (Porges 2011, Schore 2003), their nervous system is primed to the possibility of danger. This can make it very difficult for them to manage and regulate their feelings.

I asked Samina if she knew why she was coming.

She said, 'Mum says it's to talk about my feelings and to play.'

I said that her mother was right and we would have a chance to do both those things.

I asked Samina to sit at the table, on which I had already set out the Jenga, some felt pens and blank paper. She wrote her name on a piece of blank paper and I wrote mine beside it. I told her, in a warm and friendly voice, that the plan was for me to see her each week, on this day, at this time, in this room. I wrote the day and the time on the piece of the paper. I then said that whatever she told me here would be private between us *unless* she told me something that made me worried that she or someone else would get hurt. I anticipated that these boundaries of privacy and confidentiality were likely to be tested in my work with Samina, because there was ongoing risk, and Social Services involvement.

Samina wrote, 'Wednesday. 9 o'clock'. Below that she wrote, carefully, 'No one hit or shout in here with Tamsin.'

I agreed that this was a good suggestion. I was struck that she had mentioned angry, violent behaviour – the possibility of it was on her mind. I also noted that she had learned my name quickly and was confident to use it. This was encouraging in terms of her capacity to relate to another person. Samina did not seem anxious, fearful or suspicious. It seemed she was disposed at this early point to feel that I may be helpful.

Building a connection is the first job of the therapy work. Some children – due to adverse life experiences, or comm unication difficulty, or where they sit on the autistic spectrum, or some combination of all of these things – may find these apparently straightforward elements of being with another person stressful, confusing or even frightening.

The information we now had in front of us on the paper was the basis of the therapy contract we would make together. It would be explored, expanded, revisited and sometimes challenged as we worked together in the following months. It would encompass rules about being safe in the room and not hurting each other or damaging toys. It made clear that I would let Samina know if I had to be away for any reason; that she was not compelled to come; and that any artwork she produced would be kept safe in a box or folder in a cupboard. When the sessions came to an end, she could take it home if she wished.

But in this first session the details of the contract could wait … Samina's fingers were at the Jenga.

A Jenga tower can represent a structure, an actual one, like a house which may or may not feel like a safe place to live. Or it can represent a child's sense of self – it can be stable and neat, or uneven. Wobbly bricks allow us to talk about things feeling wobbly or unsafe. Removing bricks from the bottom is a chance to think about foundations and how things have to be firm on the ground if they are to stand robustly.

Samina tipped out the bricks. I wanted to follow her communications. I didn't at this point want to get sidetracked or impose