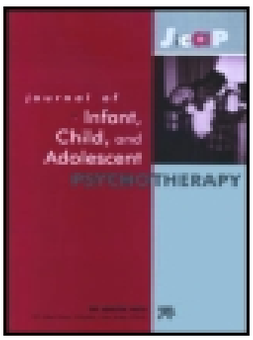

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Play Therapy for Children Inspired by Experiential Dynamic Therapy (EDT)

Ruth Derdikman Eiron, PhD

ABSTRACT

The demand for short-term therapy with a clearly defined therapy plan and operative goals, which provides deep and lasting change, is constantly increasing. This demand is especially challenging for child psychologists. While classic psychodynamic approaches to child therapy are rich in theory, they do not provide the therapist with systematic steps for conceptualization, from which detailed therapy techniques could be derived. To fill this gap, this article provides an original extension of Experiential Dynamic Therapy (EDT) well-suited for children, adolescents, and families. This method facilitates the assembly of a clear, dynamic conceptualization of the difficulties encountered by children and their families; proposes clear therapeutic tools for achieving the therapy goals derived of this conceptualization, and enables deep, stable therapeutic achievements within a relatively short time. The paper presents a case study to demonstrate these principles. This novel adaptation of the theoretical principles of EDT for child psychotherapy opens a new horizon for application of EDT in diverse types of interactions.

Introduction

Play therapy

Play is one of the main tools used when treating children, though the theory and practice of this method has been heavily debated and challenged since it was first introduced. In 1909, Freud described the first instance of psychoanalysis for a child, in which he treated a child named Hans by giving instructions to the child's father (Freud & Strachey, 1964). In 1965, Anna Freud, a pioneer in the field of child therapy, described child therapy as similar in principle to therapy for adults, although she stressed that children require a preparation phase in order to comprehend the interpretation offered. She viewed play as a highly important tool for creating a therapeutic alliance between the therapist and the child, and for developing the child's ability to comprehend the therapist's interpretation at a later stage (Freud, 1965). Melanie Klein argued that symbolic play for children was the indigenous equivalent of interpretation of dreams or free associations for adults, thus putting play therapy at the focus of her therapeutic work with children (Klein, 1975). Despite their different approaches to

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All identifying details were modified to protect the privacy of the participants.

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play therapy, both Anna Freud and Melanie Klein perceived reflective listening and interpretation as primary tools for child and adult therapy alike.

Freud and Klein developed the concept of play as a therapeutic tool as they both realized its value as a preparatory stage or as the basis for interpretative therapy. However, other scholars viewed play as the heart of their therapeutic work and considered interpretation to have little or no value in child therapy. Winnicott perceived the ability to play as a defining developmental milestone that has an overall impact on the individual's mental health. In this context, he coined the term "potential space" (Winnicott, 1971). He described play as a transitional phenomenon, existing in a paradoxical realm. On one hand, play facilitates expression of fantastic, omnipotent feelings and situations, while suppressing objective rules of reality; On the other hand, these rules are kept in mind, without mutual interference and without being forced to choose between these two polarities. The ability to exist within potential space is a fundamental condition for play that facilitates healing. "It is in playing and only in playing that the individual child or adult is able to be creative and to use the whole personality, and it is only in being creative that the individual discovers the self" (Winnicott, 1971).

Slade (1994) highlighted the role of play to create and change meaning. She argues that interpretation of play is one way of therapeutic change, a way which is often limited and inaccessible to children whose representational capabilities are immature or compromised by developmental delays. Slade emphasized that the processes occurring in playing with a therapist: Taking roles, doing things together, building narratives, meeting each other – these processes provide children with resources to make sense of emotional experiences, and to change pathological defenses.

The discussion of intersubjective processes within play therapy literature was influenced by the work of child-development and attachment researchers as well as relational theorists. Daniel Stern, and his colleagues in "The Process of Change Study Group" (Stern et al., 1998), coined the term "implicit relational knowledge", meaning the non-declarative knowledge of how "to be with" someone. Such knowings integrate affect, cognition, and behavioral/interactive dimensions. Stern et al. (1998) argued that a major therapeutic change occurs in "moments of meeting". A moment of meeting is the event, which rearranges the implicit relational knowledge, for the patient and therapist alike. Such moments are "essentially characterized by a specific recognition of the other's subjective reality. Each partner grasps and ratifies a similar version of "what is happening now, between us." (Sander, 1995, in Lyons-Ruth, 1998).

One of the prominent voices for the therapeutic process within play is Jay Frankel (1998), who perceives play as the heart of child therapy. He states that play generates initial therapeutic processes when the therapist acknowledges the patient's disassociated self-states and enables the patient to experience them fully before integrating them and initiating growth. Frankel highlighted the intersubjectivity of child-therapist play, in which a disassociated experience is converted into a structured one that can be communicated.

Antonino Ferro (1999) also perceived play as an intersubjective experience and explored how the child plays in the presence of a therapist in the bi-personal field. He claimed that during play, the child offers a narrative of feelings felt in the room at that given moment and reflects the performance of the therapeutic dyad between the therapist and patient. Ferro perceived play as a shared mental tool used by the therapist and the patient that enables the patient to contain experiences and to contemplate, primarily via projective identification (Ferro, 1999).

Despite the extensive theoretical literature on therapeutic work with children, the theories are often difficult to apply. The deep theoretical controversy between the various scholars and the abstractness of the theories described create much ambiguity regarding the actual technique to be derived from them. These difficulties are further enhanced by the ingrained complexity and necessity of working with parents and other adults in the child's life. It is therefore not surprising that this type of therapy has been described as "exhausting, frustrating, and causing many excellent therapists to leave the fascinating field of child therapy, feeling . . . helpless when facing a child and her mental world, without the familiar means for penetrating, organizing, and deciphering them" (Saroff, 2012).

One of the main reasons for this difficulty is the lack of adequate tools for clear, in-depth conceptualization that can incorporate the diverse developmental, personal, and environmental causes for the difficulties experienced by the child and family, and for defining the therapeutic technique best suited for this conceptualization. As a result of this unclarity, therapy often involves much trial and error. It becomes drawn out and unfocused, and even when it does benefit the child, it often evokes a lack of confidence and frustration in the therapist. In addition, the parents or referring institution often express their impatience and inability to understand the process and duration of therapy, resulting in inadequate cooperation and premature termination of the therapy sessions.

In the last decades, an increasing number of structured therapies for children were developed, most are designed to treat specific diagnoses or symptoms, often with a behavioral focus. Despite their usefulness in some cases, many parents and children struggle to use these methods, due to their lack of ego capacities or skills (Midgley et al., 2017).

Two recent models offer structured, clear focused play therapy based on psychodynamic principles: Mentalization based Therapy for Children (MBT-C) and Regulation Focused Psychotherapy for Children (RFP-C). MBT–C aims to help children and parents suffering from various problems, by focusing on a core capacity that may promote resilience in children. This is a structured, short term program (15–16 sessions including evaluation phase), which uses non-directive play therapy. A central aim of the individual work with the child is to develop the capacity to recognize, endure, and regulate emotions, by developing a reflective capacity, regarding her own feelings and thoughts, as well as others. In a parallel process with the parents, the therapist will aim to enhance their reflective capacity regarding themselves and their child (Midgley et al., 2017).

RFP-C is a structured, short-term therapy method for children with externalizing symptoms, mostly of oppositional and disruptive behavior. This method uses non-directive play therapy, to identify children's defense mechanisms against unpleasant feeling states. Systematic interventions promote the development of improved implicit emotion regulation capacities and increase children's ability to tolerate painful emotions that were previously masked by the disruptive behaviors (Prout et al., 2020). Despite their use of non-directive play therapy, these methods are semi-structured, manualized interventions which explicitly target the child's mentalization capacities or defense mechanisms. They do not use play as means to work primarily and directly with children's feelings.

This paper presents a novel adaptation I have developed for Experiential Dynamic Therapy (EDT) with children, based primarily on Winnicott and Frankel's approaches to play therapy. I believe that this adaptation addresses many of the problems experienced when working with children. This method offers a solution for developing dynamic conceptualization of the difficulties experienced by the child and family that is both simple, comprehensive and can be communicated to the significant adults in the child's life who are not mental healthcare professionals. A focused, active technique is then derived from this conceptualization to shorten and streamline the therapy process as much as possible, and achieve profound, stable results within a relative short period of time. I will begin with a brief overview of the concept of focused therapy, followed by an explanation of EDT principles and its adaptation for children.

Focused therapy

The various types of focused therapy are based on the shared assumption that the psyche has a specific and consistent way of contending with emotional distress that is selected because of its high adaptive value, and emerges in various ways in different contexts (Zlotnik, 2007). For example, A child suffering pain due to rejection, may respond strongly to stimuli that is related to this sense of rejection. The child may respond to parental rejection at home with angry outbursts but will join a group at school that harasses unpopular children to feel less rejected. The difficulty may be less apparent under certain circumstances but will emerge in other contexts when available coping mechanisms do not suffice.

During focused therapy, the therapist will attempt to identify the central issue or source of pain in the patient's life as quickly as possible. Through mutual discussion, patient and therapist will form

a tentative conceptualization of the case, which will yield a consent of therapy goals and means to achieve them. The conceptualization and the goals may be redefined during therapy but are always in the therapist mind.

Although focused therapy was originally born of the need for shorter-term therapy, it has created a new category of therapies, which are not necessarily short-term. EDT falls within this category.

EDT and its adaptation for child therapy

Experiential Dynamic Therapy (EDT) (Davanloo, 2000; McCullough et al., 2003; Osimo & Stein, 2012) is based on an approach that considers the source of emotional difficulties and distress as blocked adaptive feelings. Contact with these feelings, and the ability to express them in an adaptive manner, was blocked during the early years of the patient's life by the early attachment system to which the individual was exposed, namely the relationship with parents or significant others, in which emotional experience develops.

Feelings may be blocked for one of three main reasons:

(1) When a parent objects to the child's behavior due to certain personal conventions or beliefs, and the parent conveys to the child that this behavior is undesirable or punishes the child for it.
(2) When the child's behavior evokes conflicts from the parent's past, making it difficult for the parent to recognize the needs of the child, to regulate parental response to that behavior, and to find appropriate ways to regulate the child's feelings and address the child's needs. In cases such as these, the parental response may be neglectful, invasive, or overwhelming, and may cause the child to become fearful or alone with these difficult feelings (Cohen, 2017), and possibly to block these feelings later in life.
(3) At times, parents struggle with their roles because of their own distress or unmet needs, which they project upon their children. The child then attempts to fulfill these needs by blocking out the impressions, experiences, and feelings that the parents don't want the child to know about, in order to protect themselves and the quality of care they provide for their child. In cases such as these, it is unsafe for the child to "know what he knows, or feel what he feels" (Bowlby, 1988).

EDT describes the conflict associated with expression of blocked adaptive feelings, using a diagram comprising two triangles, known as Malan's Triangles (Malan 1979, McCullough et al., 2003). Schematic identification of the conflict using this triangle model is the basis for dynamic conceptualization that directs the initial therapy goals and provides an outline for the therapy process.

At the bottom vertex of the triangle of conflict (Figure 1) are the blocked adaptive feelings. Appropriate expression of these feelings would mobilize positive feelings and optimal ability to function and cope with life's challenges. McCullough et al. (2003) listed eight adaptive feelings: assertion\anger, sorrow\grief, fear, closeness\tenderness, positive feelings toward oneself, interest \excitement, enjoyment\joy and sexual desire. These feelings may be blocked during early childhood, as part of the attachment system encountered by the child at that stage in life. When a blocked feeling is mobilized in response to an external or internal trigger, the inhibitory affect is triggered in conjunction, to keep the feeling blocked and avoid confronting the difficult experience associated with expressing the feeling. These inhibitors can appear in the form of diverse feelings such as anxiety, guilt, shame, or disgust (McCullough et al., 2003).

All inhibitory affects, particularly anxiety, are powerful and efficient mechanisms for blocking feelings, however require significant emotional resources. Therefore, in most cases, a defense mechanism is enabled, to prevent the blocked feeling from manifesting in any way. A defense mechanism is any method the individual develops in order to keep the feeling blocked and can range from an effective and socially acceptable mechanism, to a difficult and extremely unacceptable one. All symptoms are considered in this model as defense mechanisms. For example, an individual whose mother suffered from depression during his infancy would learn that expressing sadness causes his

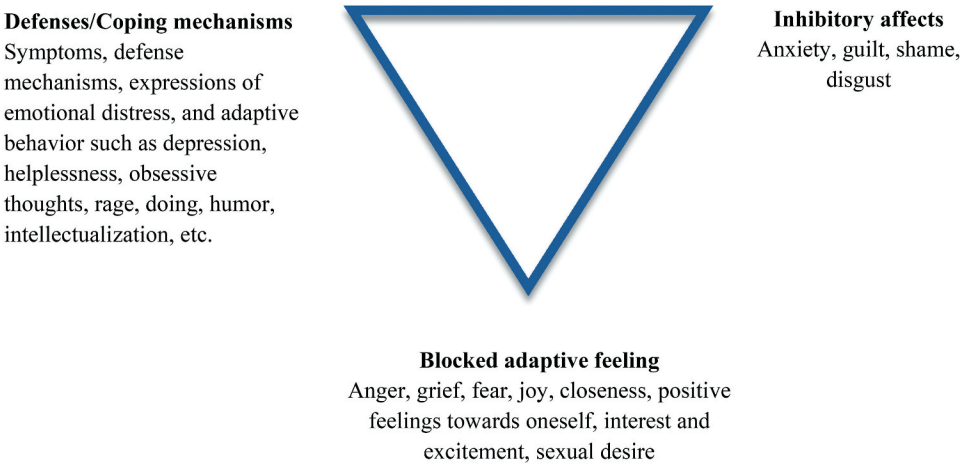

Figure 1. The Malan Triangle of Conflict (Kuhn, 2014; McCullough et al., 2003). Reprinted with permission.

mother to withdraw and leave him alone with that sadness, while his laughter and happiness makes her happy and encourages her to endow him with attention and affection. This child might grow up to be an entertaining adult with a good sense of humor. If this coping mechanism is beneficial for this individual, it causes no harm. However, if during adulthood he fights with his spouse, feels sad and responds with humor because that is how he has learned to cope with sadness, he might enhance the conflict and damage their relationship.

The theoretical assumption (Davanloo, 2000) is that when a blocked feeling is experienced in the beneficial presence of the therapist, the individual feels tremendous relief and no longer needs the defenses undermining his ability to function and compromise his quality of life. In the example above, the individual would thus be able to express sadness in the presence of his spouse instead of detaching from his sadness and using humor instead. This does not necessitate a loss of his sense of humor, but rather will enable him to choose when it is appropriate to utilize humor as an effective coping method. This allows the individual to control which coping method to use, instead of being controlled by his defenses.

The second of Malan's triangles is the Triangle of Person (Figure 2), which describes the contexts and methods in which the conflict is expressed. The bottom vertex of the triangle describes significant relationships during childhood, particularly with the individual's core family members. These

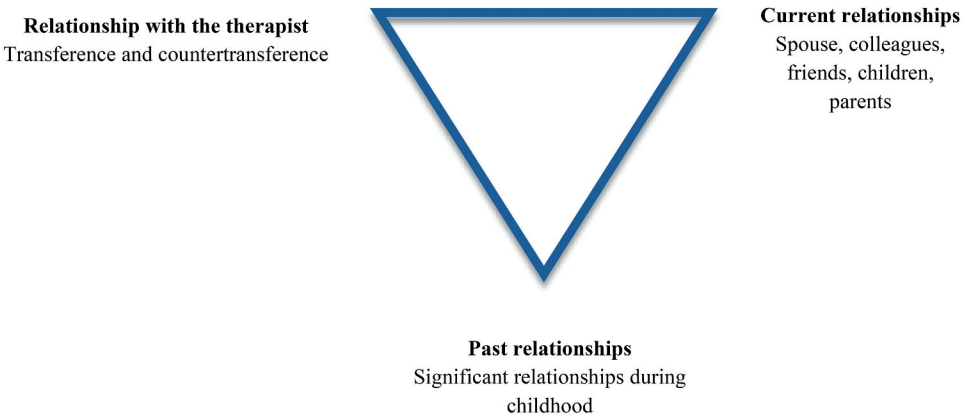

Figure 2. The Malan Triangle of Person (Kuhn, 2014; McCullough et al., 2003). Reprinted with permission.

relationships form the contexts in which individuals learn how to block and cope with their feelings. The vertex on the right describes current relationships – with spouses, colleagues, friends, children, and parents. The vertex on the left describes the individual's relationship with the therapist (transference and countertransference).

I have developed an additional means of conceptualization based on this approach called the Tragic Spiral. This spiral describes a relationship that is somewhat tragic, as the more the individual strives to fulfill her legitimate healthy needs, the more distant they become because of the ineffective methods employed. In many cases, the situation continues to escalate until the main defense collapses, and more primitive defenses arise (see Figure 3).

The Tragic Spiral describes a process in which either an internal or external stimulus mobilizes a feeling or a blocked adaptive need. An inhibitory affect is then activated to prevent the blocked feeling from emerging, which triggers the primary defense mechanism that the individual activates automatically. A second stimulus mobilizes the feeling even more powerfully than before, which activates an even stronger inhibitory affect and defense mechanism. This cycle continues until the main defense mechanism can no longer withstand the intensity of the blocked feeling and collapses, and the individual retreats toward the primitive defenses that require more resources.

A child who is jealous of a sibling and angry at a parent for paying more attention to the sibling than to her, might use placation and good behavior as defenses against her jealousy. When the parents endow the sibling with attention or praise, she might respond by being as placative as possible, in order to attract their attention. However, this does not fulfill her genuine need to express anger and jealousy. As similar situations are repeated, the blocked feeling becomes more intense. This, in turn, intensifies the inhibitory affects (guilt for feeling angry, shame at the intensity of the aggression this evokes). As the process escalates, the transitions between the stages (blocked adaptive feeling → inhibitory affect → defense) are accelerated. She becomes trapped in this spiral of feelings and begins to experience an unconscious fear as she gets closer to terrifying archaic self – areas. Eventually, the main defenses can no longer cope with the intensity of the feelings and they collapse, leaving only lower-level, more primitive defenses, such as angry outbursts.

In my opinion, the blocked feeling in the Malan triangles represents only part of the emotional process. The young child experiences a parental reaction that is generally recurring and leaves the child scared and alone with her fears as she experiences emotional intensity that she is incapable of

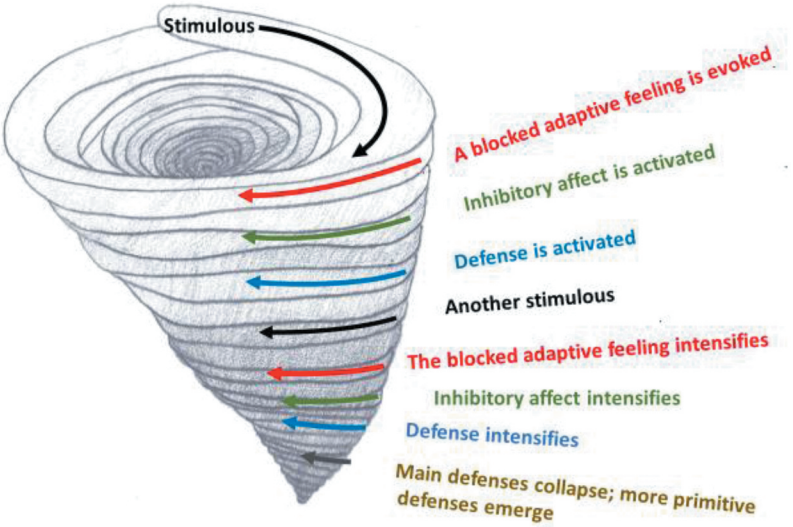

Figure 3. The tragic spiral (illustration: Shira Derdikman, published with permission).

containing. The experience is not assigned any words or meaning, as there is not yet a self that can attribute words or meaning to the experience. Bollas (1987) coined for this the term "unthought known", and Winnicott (1963) described it as "fear of breakdown". Winnicott used the term to explain how many pathological phenomena are in fact defenses developed to protect the individual from "primitive agonies" *that have already occurred in the past*, though this information is not readily accessible to the individual's current experience or consciousness. To avoid this preliminary, chaotic, inconceivable, and incomprehensible experience, the individual blocks feelings experienced as related to or associated with this chaos or fear. Thus, in addition to the blocked feelings described by Malan's triangle model, an additional tier is added here to relate to the existential experience or deep wound that is associated with these fears, which describes the unique expression of this wound in the specific patient. Common topics associated with these primitive agonies are as follows: needs for mirroring; safety; competence feeling; interpersonal relationship; trauma and loss; fear of breakdown. A similar approach was described by Osimo, who formulated a "character hologram" for his patients that metaphorically summarizes profound information about the dynamics of the individual's personality, which is also related to the existential experience that formed the foundations for the blocked feelings (Osimo & Stein, 2012).

When applying EDT to adults, the therapy shifts between the three vertices of the triangle of conflict– feelings; anxiety; defense (Figure 1). The therapist attempts to mobilize the patient's blocked feeling in order to trigger the inhibitors, which the therapist regulates, and the defenses, which the therapist identifies, blocks, or attempts to alleviate along with the patient, in order to get as close as possible to the blocked feelings. The working assumption is that to facilitate healing, the patient and therapist should experience the blocked feelings together. This explains why the method described here is termed "experiential". The blocked feelings are mobilized using active measures that occasionally put pressure on the patient and produce powerful feelings of anger, sorrow, and grief toward the people who comprised their early attachment system. This process ultimately leads to relief, compassion, and acceptance. However, the intensity experienced before achieving these positive results is generally unsuitable for children, who lack the verbal and conceptual skills needed to contain these powerful feelings. Furthermore, children and adolescents usually live with their parents, within their early attachment system, and are dependent on them, and therefore they lack the necessary distance and perspective required to process the anger, rage, and grief that might be evoked by such powerful emotional activation.

This paper describes adaptations made on EDT for working with children, especially with regard to the triangle of person, and how working with feelings could be adapted for play therapy. In future articles, I will describe additional aspects of experiential therapy, particularly in relation to couple's therapy and family therapy, and will discuss integration of different therapy methods within the theoretical framework of focused experiential therapy in general and EDT in particular.

Evaluation and conceptualization in focused EDT for children

Formulating the initial conceptualization in child therapy, using the EDT framework, involves drawing the triangle of conflict, the triangle of person, and the Tragic Spiral. Generally, four to five sessions are required to collect the information needed to develop the conceptualization. The first session involves a detailed intake with both parents, preferably together. Two sessions are held with the child, which include an interview, free play, drawing a house, tree, person, and family (HTP), and a picture-story test based on CAT or TAT (Thematic Apperception Test; Murray, 1943), depending on the age of the child. Based on the findings from these three initial sessions, a subsequent joint session is held with the nuclear family, including the parents, some or all the siblings, or several dyads, in order to conduct an initial assessment of family dynamics. I conclude this initial evaluation phase by meeting the parents and summarize my findings. I present the conceptualization (including the Tragic Spiral), adjust it along with the parents, and propose a therapy plan. This evaluation process helps create an initial understanding of the child's emotional dynamics, the contribution of the familial relations to

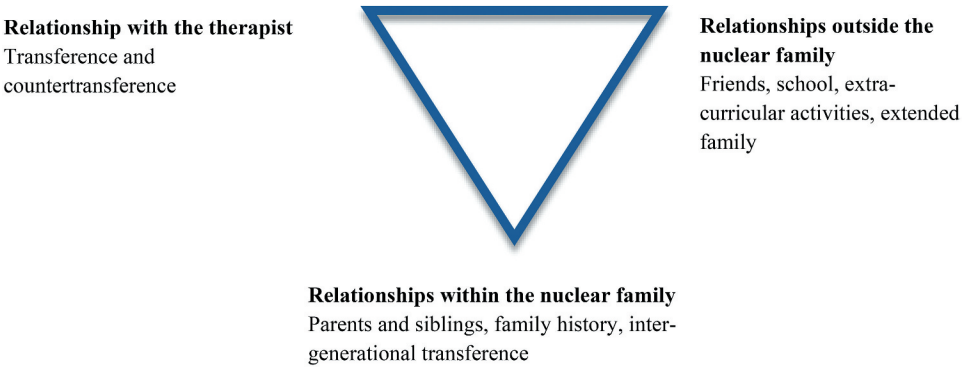

Figure 4. Adaptation of the Malan Triangle of Person for Child Therapy.

the symptoms identified, and the implications of these symptoms within the family framework. The shared process of defining clear conceptualization facilitates the therapeutic alliance between the parents and the therapist, a critical factor in child therapy.

One of the main differences between conceptualization in child therapy relative to adult therapy is how the Malan triangle of person is adapted. In the original triangle used for adults, Malan distinguishes current relationships from past ones, while referring to the patient's family of origin as the setting in which current patterns of behavior and emotional repression were first acquired. In child therapy, the early attachment system, in which the feelings were blocked, and the emotional experience was developed, is still active. Therefore, the triangle of person was slightly modified (Figure 4). The bottom vertex describes the early attachment system, which is still active in the child's life. It describes early patterns in the child's relationship with her parents and siblings, including the myths, beliefs, and traditions that comprise the family experience, and the significant patterns of inter-generational transference that can explain the system that is causing the child to block certain adaptive feelings, and is creating the fundamental existential experience. The vertex on the right describes relationships outside the family circle (friends, teachers, counselors, peers, extended family, and other children and figures in the child's life). The vertex on the left describes the child's relationship with the therapist (transference and countertransference).

Working with feelings in focused EDT for children

As explained in the previous sections, methods for working with feelings when treating children require certain adjustments. However, there are several ingrained advantages in therapeutic practice with children that contribute to its effectiveness. First, children are naturally more inclined toward experiencing and playing, making it easier to work with them on these levels. Second, their defenses are usually not as rigid as those of adults. In addition, the fact that children still live within their early attachment system makes it possible to influence this system and generate powerful change by working with the parents or with other dyads/family members, as opposed to adult therapy, in which often the only possibility is to accept and grieve over lost opportunities.

Like other types of experiential therapy, Focused EDT with children pays close attention to emotional observation and emotional expressions. The process involves identifying a specific feeling in the body, with the aid of the therapist's mirroring, analysis of events, and role-play. The patient and therapist focus on ongoing feelings and mobilized feelings. They explore and emphasize proper cognitive naming of the feeling, and, more importantly, play out and play with the feeling.

There are several ways of playing out a feeling or playing with it. The first is by modeling contact with a blocked feeling. For example, a therapist might initiate a demonstration of anger by acting out an angry person during a play session or increase the intensity of a feeling through manipulation (intentionally angering the patient, or exaggerating anger while playing). This legitimizes the existence of anger in the room

and the willingness to confront it. The second way is providing a model for coping with an unbearable feeling. For example, if the therapist identifies sadness as the blocked feeling of the patient, she can model possible ways of coping with sadness in the play setting. The distance that is achieved by playing with the feeling in an imaginary world offers much more freedom of choice and action both to the child and to the therapist. Another option is to encourage the child to be in a position of control and free choice when faced with a feeling that usually leaves her feeling helpless. For example, if she feels frustrated in the family setting, the therapist might act out a character that feels frustrated, unsatisfied, and sad, and allow the child to choose a role in the game from a position of control and free choice regarding the situation, unlike the perspective from which she usually encounters this feeling. The child might choose to act out the person causing frustration, or suggest ways of overcoming it.

This mode of work with feelings is typical of play therapy. However, while classic therapy generally requires the therapist to act based on intuition or trial and error, occasionally through projective identification, in the current adaptation of Focused EDT to child therapy the therapist employs dedicated tools now available in her arsenal: conceptualization and the Tragic Spiral, which facilitate more focused attention to blocked feelings and painful existential experiences. From my experience as a therapist, even work with projective identification becomes clearer and easier when it is part of a dialectic process that involves conceptualization and theoretical understanding on the one hand, and openness to intersubjective experiences that clarify the conceptualization on the other hand.

Case study

During my first meeting with Jonathan (age 9), I noticed that something in his appearance was not quite age appropriate. His childish charm and gentleness seemed to be concealed by a semi-transparent, impenetrable shield. He immediately chose to play with Lego and began to assemble the pieces very meticulously and rigidly, with hardly a glance in my direction. He generally ignored my attempts to make conversation and play together or muttered his refusal when I insisted. I felt something inside myself withdraw, wishing on giving up. Thoughts on how to escape this therapy kept running through my head. Concurrently I felt a sense of guilt and commitment to my chosen profession and to his parents, whom I had already met.

Jonathan was referred for therapy by his parents, who described him as quiet and introverted, but very stubborn, with a tendency toward angry outbursts at home. They told me that he struggles to talk about his feelings and often withdraws, but occasionally responds in anger outbursts for no obvious reasons. When asked, he is unable to explain what upsets him, and even when he calms down, he is incapable of having a conversation with his parents about the incident. Jonathan's parents complained that they could not understand him and could not help him regulate his feelings. They described feeling a sense of failure (more from the mother), anger (more from the father), and helplessness (from both parents). Jonathan was suffering from various phobias, and occasionally would say that he did not want to grow up.

Jonathan has excellent analytic and technical skills. He is good at mathematics, and at assembling puzzles. However, he struggled with reading comprehension and a psychological evaluation found significant difficulties with verbal skills, which compromised his grades in mathematics as he struggled to comprehend word problems. He has one close friend who he occasionally meets. He takes part in a scouts group and play soccer.

Although Jonathan participates in these activities on a regular basis, his father was not satisfied with his performance and described Jonathan as passive in both activities.

Jonathan's brother is three years younger than him. His brother has a great deal of personal charm, causing Jonathan to feel jealous. His parents immigrated to Israel when they were young from a culture that prioritizes intellectual achievements and attributes less value to feelings.

From the projective material of Jonathan's evaluation, it seemed that Jonathan had partially positive introjected objects and some positive image of the world, but the access to them was blocked. Despite his awareness, he felt unworthy of the good they may offer and tried, not always successfully, to solve his problems alone. He was attracted to fantasy, but did not allow himself to fantasize freely, and stuck

rigidly to familiar stories of Harry Potter over and over. He was trapped in a circle of rage, anxiety, guilt and helplessness, as can be seen in his story to card 3B in TAT: "A child is crying. Puts his hand on the bed and cries. (why?) Because his **elder** brother insulted him. He will later stop crying, open the door and will throw his brother to the toilet. And then he will fall on his butt and will feel bad as his **younger** brother did" (emphasize added to mark his confusion, caused by anxiety over rage). In this story, Jonathan portrayed rage, anxiety, and guilt over rage, which caused helplessness and self-punishment, exactly as described by Davanloo (2000).

Following the evaluation process, I developed the following conceptualization (Figures 5 and 6):

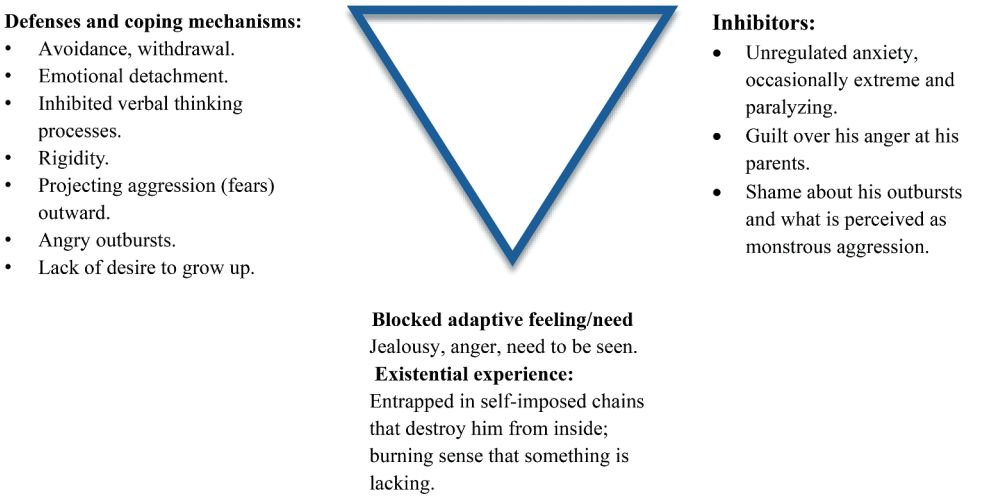

Figure 5. Adaptation of the Malan Triangle of Conflict for Jonathan's case.

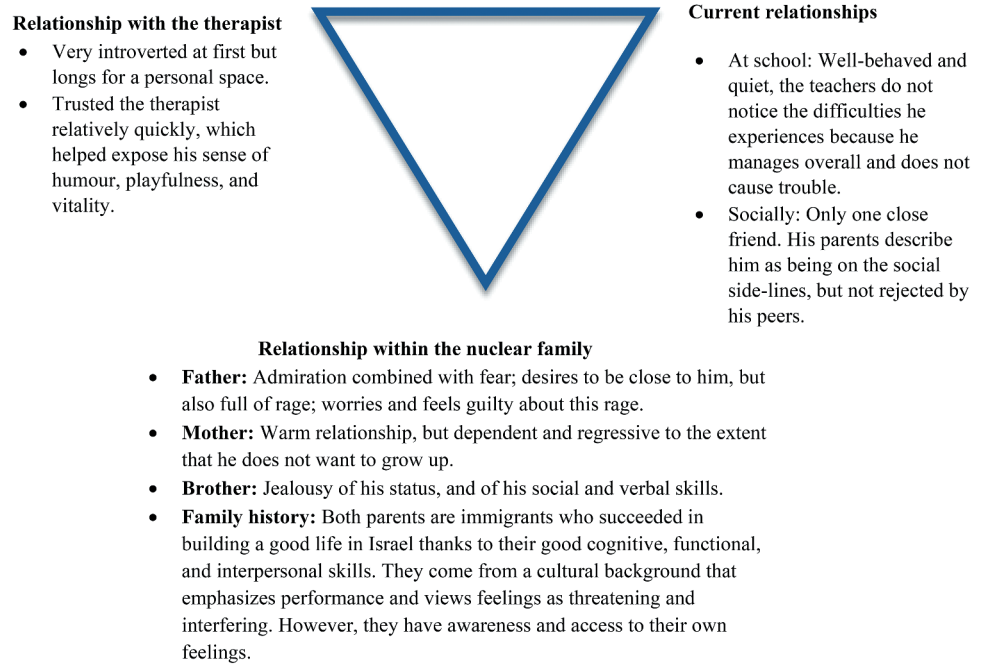

Figure 6. Adaptation of the Malan Triangle of Person for Jonathan's case.

The Tragic Spiral that demonstrates typical dynamics (Figure 7):

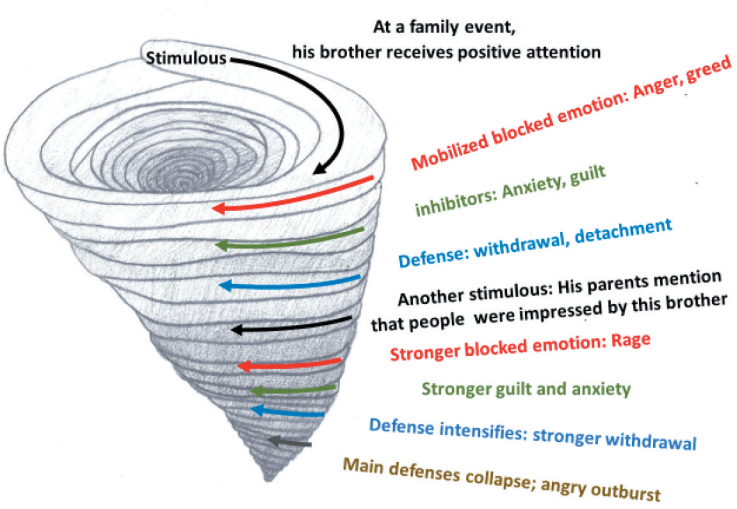

Figure 7. Jonathan's tragic spiral (illustration by Shira Derdikman, published with permission).

The Tragic Spiral describes typical dynamics in the family, in which Jonathan attempts to overcome his jealousy and anger by detaching himself from the situation and avoiding contact with his family. This behavior results in him receiving less attention and recognition, which only increases his anger. In addition, the enormous effort he invests in detaching and withdrawing results in reduced thinking skills and impaired ability to generate meaning and explain what happened, and to use thinking processes for emotional regulation. Eventually, Jonathan can no longer control himself and explodes. As he is detached and withdrawn and feels guilty about being so, he is incapable of effectively communicating with others and explaining what happened.

Therapy process

Based on the initial conceptualization, the therapy goals defined were the need to work on Jonathan's blocked feelings of anger and jealousy, and to educate his parents how to allow Jonathan to process his feelings. During therapy, the issue of greediness emerged as well, and this became the focus when processing the emotional experience. A second goal was to avoid reinforcing non-adaptive defenses, as described above in Jonathan's triangle of person. One example would be to help Jonathan's mother find ways of providing Jonathan with support and warmth without encouraging avoidance or regression, and to encourage his father to see his son for who he is, for better or for worse, and develop a closer relationship with him. This could help minimize the anger he feels and create a better sense of confidence and competence.

Despite the initial difficulty I experienced when I first met Jonathan, from the onset he was highly motivated to attend our meetings and craved for a relationship. He spoke enthusiastically about characters from his favorite stories and cartoons, and his charm and humor began to emerge. However, I was unable to connect the different parts of the conversation with him and understand why his eyes would suddenly begin to shine and he would burst into laughter when recounting a scene from a movie he saw. I felt like I was awkwardly following his lead, collecting fragments of information and meaning, and making feeble attempts to connect with Jonathan without receiving a clear response from him. Eventually, my efforts began to bear some fruit and I began to feel the beginning of a relationship developing between us, as I made a significant effort to see him and understand him. As

we developed trust in our relationship, I was constantly aware of the issues raised during the evaluation processes, namely anger and jealousy, and attempted to "sneak" them into our games and encourage Jonathan to touch upon these feelings playfully at every possible opportunity. I will describe how the therapy process developed as we worked on issues of anger, jealousy, and greed. Each issue will be presented separately, for the sake of clarity, however they were obviously intertwined during the sessions themselves.

The first opportunity to talk about anger arose when Jonathan told me that his friend was "annoying". Based on the theoretical understanding (Davanloo, 2000) that every feeling triggers action, I asked what he wanted to do to his friend. Jonathan said that he wanted to send him to Mars. Several sessions later, Jonathan described a disappointing card in a game as "annoying" as well. When I asked what he wanted to do to the card, he looked at me questioningly. I suggested sending it to Mars, as he had suggested doing to his friend. This triggered a playful, funny brainstorming session about the different punishments that could be inflicted on the card, including burying it in the snow in Antarctica and sending it to Mars, as I intentionally manipulated and enhanced the emotional aspect of the conversation. After several minutes of aggressive playfulness aimed at a third party (the card), Jonathan began to indicate a certain degree of anger at his friends and his father. Toward the end of these sessions, he would hide when his father came to get him and "shoot" him with a toy gun. His father played along, and Jonathan seemed to enjoy that very much.

The games we played exposed Jonathan's preference for games in which I lost and complained about losing, injustice, or my own helplessness. We played a game in which he was a seller and I was a buyer who attempted to buy endless items, even when I ran out of money. I ignored the boundaries he set for me and yelled and stamped my feet while insisting on taking home all the products in the store. Jonathan seemed a bit shocked at first but recovered quickly and enthusiastically asked me to repeat the scene again and again.

At a later session, he became assertive and aggressive toward me while we played a symbolic game, and thoroughly enjoyed seeing me loose. I experimented with different reactions to loosing, such as interpreting my loss as his desire to hurt me; how he wanted to have more than I did; and different expressions of anger and sadness. However, my only reaction that Jonathan was tuned to was asking me to pretend I am sad and to complain about the injustice, while he laughed with pleasure.

I began to comprehend that Jonathan enjoyed situations in which the rival could humiliate his opponent and make him feel deficient and helpless, while he celebrated his own abundance, a sense associated with greed (Klein, 1975). In our games, I highlighted the sense of injustice and helplessness that I assumed he had experienced with his brother, his family, and in social settings. While playing these games, I used play to feel his blocked feelings and to express his sense of helplessness and injustice when faced with his brother's verbal and social skills, and with the admiration his brother was receiving. The games we played placed him on the opposite side of a familiar situation. This time he was the strong one, the person in control. In my role in the game, I modeled a reflection of these feelings, and legitimized their expression. This gave Jonathan an opportunity to cope with his feelings, experience his aggression, and accept the feelings when they emerged inside him.

Over time, after being somewhat sadistic toward me, Jonathan managed to display compassion and a desire to help me. At this point, our relationship began to flow. I could feel Jonathan's excitement about the game, and it was contagious. I became highly attentive to the content and feelings that emerged while we played, and I felt more confident in the world of playfulness we had constructed.

Jonathan's progress can be demonstrated by the changes that occurred when we played Monopoly, a game that we played often during his therapy. At the beginning, Jonathan played carefully and followed the rules. Later, he started to cautiously test his boundaries. He decided not to pay taxes when he did not want to; he put back Chance cards that he didn't like and chose different ones instead and tried to apply his improvised rules to me as well. Eventually, he started paying his debts using money from the bank instead of his own and took more money from me or from the bank than he deserved. Finally, he started ignoring the rules entirely and took money, refused to pay his debts, demanded higher payments from me, changed the rules from one minute to the next, and made me go bankrupt

within minutes. I responded to this behavior by trying to play different roles and see what served his needs. He did not respond to interpretations about him wishing for more, or about his desire to hurt me. However, he was very responsive to my expressions of discrimination and humiliation. He asked me to repeat them until he finally calmed down, felt some compassion for me, and lost interest in the game.

In addition to those games we played that manifested anger and greed, we also addressed Jonathan's interest in words. During one of our sessions, he asked me to explain the difference between playing tricks and cheating. He was also interested in the precise meanings of definitions of different words. I was impressed by how he used his phenomenal memory and his great interest in weather to develop explanations and rules. I was happy to learn from his parents that his improved verbal abilities also contributed to his emotional discourse and regulation, and to improved verbal performance at school.

During my sessions with Jonathan's parents, I encouraged his father to strengthen his relationship with Jonathan by devoting time for shared activities. We brainstormed together on how to reinforce Jonathan's status as the eldest child, capable of accomplishing more sophisticated tasks thus having more responsibility than his younger brother. I tried to diminish his father's criticism over Jonathan's achievements in soccer, and over Jonathan's participation in social activities. I worked with Jonathan's mother on maintaining their emotional bonds; reinforcing Jonathan's ability to talk about his feelings and regulate them using inner speech; controlling regressive behavior and encouraging more mature behavior; and not reinforcing avoidance and withdrawal even if his mother identified with his need to act this way.

After one year of therapy, there was a significant improvement in Jonathan's ability to regulate himself, and there were significantly fewer outbursts of anger. He became capable of using his inner speech to regulate himself, was capable of describing his emotional experiences and could discuss incidents after they occurred. He became increasingly interested in nuances of language at home as well as in therapy, and significantly improved his grades at school, both in math and in reading comprehension. His recurring fears diminished significantly, and he no longer expressed the desire to remain little and not grow up. In a follow-up conversation 18 months after therapy termination, Jonathan's mother reported that therapy achievements were maintained. Jonathan was attending a class for excellent students at his junior high school and adapted well both academically and socially.

Summary and discussion

To an external observer, Jonathan's therapy might have looked similar to classic play therapy. Jonathan chose the games he wanted to play, and I played with him and tried to participate in the way that I thought would be best for him. However, there are two significant, interrelated differences between Focused EDT adapted to play therapy vs. the classical form of play therapy.

The first difference is related to **dynamic conceptualization**, as described using Malan's triangles (adapted for children) and the Tragic Spiral. Conceptualization facilitates an initial formulation of the issues on which therapy will focus, while leaving room for changes. In Jonathan's case, therapy focused on anger as a blocked adaptive feeling, and on isolation of affect and disconnection, that served as defense mechanisms and impaired his ability to use words to regulate his feelings and reactions. Issues related to greed emerged later as central to Jonathan's experience, and gradually became more and more dominant in therapy. The schematic way the conceptualization is formulated helped me clearly communicate my insights and plan of action to Jonathan's parents. This formulation creates a sense of confidence that contributes greatly to the development of a therapeutic alliance between the parents and the therapist, which is, of course, crucial for the success of the therapy.

In classic therapy, the insights and diagnosis are developed dynamically over the course of the session, but there is no consistent, clear way of constructing them and communicating them to the child or the significant adults in his or her life. Frankel (1998) described his response to a school psychologist who asked him to formulate what was happening during a specific therapy process:

> For a moment I was stumped. Jim and I had never formulated the meaning of our play out loud (**nor had I felt I could definitively formulate it to myself**). I occasionally found a word to label the atmosphere of the play or to say how my character, or his, was feeling. Mostly, we just roared. With Jim, playing was therapy. Interpretive comments at this phase would have meant taking a break from playing and might have made the therapy a less welcoming place to play (p. 155, emphasis added).

Despite the playful charm of Frankel's account, I prefer to take a different stance. In my opinion, conceptualization is not necessarily related to premature interpretation, or to interpretation at all. Basically, many therapists can gain from working in a dialectic mode, by always keeping the conceptualization in mind as a general, tentative "roadmap" for therapy, while being open and aware of various issues, experiences, and feelings, which arise.

The second difference between classical play therapy and EDT inspired play therapy lies in the therapist's conscious effort to **incorporate feelings** into the therapy, either deliberately or by enhancing and encouraging feelings that emerge spontaneously in a refined or implicit manner while the child plays. Although the process of EDT with children is very similar to Frankel's description of his play therapy sessions (Frankel, 1998) the conceptualization, focus, and active involvement facilitates a shorter therapeutic process that does not compromise on the level of change or on the depth of the experience.

In Jonathan's case, his improved ability to contend with anger in the room, experience aggression and greed, and practice expressing these feelings in a safe, beneficial environment, reduced his need to activate inhibitors such as anxiety and guilt regarding these issues. He no longer needed the defenses that caused deep detachment of the feeling and disrupted verbal thinking processes. These processes became less threatening and Jonathan gained the ability to use verbal tools to think, regulate, and explain. Working in parallel with his parents helped support and reinforce these processes.

The conceptualization helped focus the therapy process and accelerate it, so that the whole change occurred within one year. Specifying the therapeutic intervention and enabling effective communication of the therapy process to the parents, strengthened the therapeutic alliance with them. Actively incorporating emotional issues furthermore contributed to the therapeutic alliance, facilitated Jonathan's trust and confidence, and enabled him to gradually touch upon his blocked feelings. These factors helped streamline the therapeutic process and make it more effective, while yielding profound, stable changes within a relatively short time.

MBT-C and RFP-C, described earlier, are two other current models of child therapy, which combine case conceptualization and play therapy. MBT-C (Midgley et al., 2017), aims to help children and their parents by focusing on a core capacity that may promote resilience in children, and help parents "think" the child. Although mentalization is a basic capacity which promotes resilience and can improve children and parents' quality of life tremendously, it does not offer, nor promises to offer, a full therapeutic plan. EDT for children uses mentalization when working with children and parents, however it aims to treat a wide variety of psychological difficulties.

RFP-C specializes in promoting regulation capacities in children with externalizing symptoms. It is similar to EDT in its use of Malan's triangles. However, it uses only one triangle of the two, the triangle of conflict, and focuses on identifying and restructuring defenses (McCullough et al., 2003). This method helps the child understand her behavior as a defense mechanism against another feeling, and change it, but it does not deal directly with the blocked feeling. According to their therapeutic vignettes (Prout et al., 2020), the therapist mirrors and interprets the child's free play, but does not "sneak" into the play to help expressing the blocked feeling. This deliberate use of play is at the heart of EDT for children. In addition, both MBT-C and RFP-C use interpretation as one of their main therapeutic tools. EDT for children may use interpretation, but mainly aims to create and change meaning via play. In line with Slade (1994), this is particularly important when working with a child whose ability to use interpretation was compromised at therapy onset, like Jonathan. EDT for children, like all experiential therapies, strives to create "moments of meeting" (Stern et al., 1998) and sees the experience as the main tool for creating change.

Both MBT-C and RFP-C show good evidence base. A research is still needed to evaluate the effectiveness of EDT for children.

Despite its strong dynamic roots, EDT for children is integrative by nature. In Jonathan's case, play therapy was dominant, but parents meetings used mentalization and defense restructuring as main tools.

The integrative nature of child therapy is twofold: Integration of therapeutic methods, such as play therapy, developing mentalization capacity, affect regulation and CBT, and a systemic understanding, which will integrate information and work with parents, teachers, and all other relevant stake holders. As a result, training in child therapy may be exhausting, complicated, and may feel scattered without a clear framework. The suggested model provides clear, deep conceptualization, which arranges various techniques under one framework. Adding this model to therapists' training may reduce therapists' feelings of helplessness and burnout and increase therapeutic effectiveness.

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