

FOCAL PLAY-THERAPY IN THE EXTENDED CHILD-PARENTS CONTEXT

A Clinical Case

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“The youngest child already doesn’t want what adults want”

W. METZGER

Introduction

Clinical practice and research on preschool children with eating and evacuation disorders showed the appearance and maintenance of psychosomatic protest behaviors when the family coercively imposes its system for eating and evacuation (CANESTRARI & TROMBINI 1975; BALDARO & TROMBINI 1989; BALDARO, TROMBINI & TROMBINI 1994; BALDARO 2002; E. TROMBINI 2002). The child’s basic need, the motivation to do by oneself (which appears around the second year of life) is frustrated (KEMMLER 1957; G. TROMBINI 1969, 1970; ARFELLI GALLI 1995). The pride in his performances and aspiration to grow up replace the past desire for help. He wants to be independent in all those activities which are at the limit of his capacities, therefore the freedom consciousness becomes the focus of self consciousness (METZGER 1959). The request to do by himself simply focuses on the “I do” which the family can either obstruct or encourage not only by stimulating the child but by also previously allowing him to develop satisfactory attachment relationships (BATTACCHI & GIOVANELLI 1988).

The appearance of the motivation to do by oneself is related to the relational dynamics inside the family context. According to LICHTENBERG (1989) motivational system theory this motivation is part of the exploratory-assertive motivational system but it is only related to the aversive motivational system when the child is forced to signal a lack of correspondence between his needs and the caregiver’s behavior. When the child effectively becomes a family member, receiving the same esteem as the other members of the family and maintaining a continuous reciprocal communication, a common life in which a behavior led by the motivation to do by oneself is coherent with the feeling to be “I” but also part of “we” will be possible. In this case, the motivation to do by oneself is congruent with the need to be part of and to be well integrated in a harmonic family life. In contrast, when becoming part of the family life reality is complicated by the coercive adult intervention, the child can painfully feel to be detached from his context. As a consequence, opponent and psychosomatic protest behaviors can appear to signal that the caregiver behavior is inadequate and to regain the lost autonomy. Although signalling the need of an autonomous behavior, the psychosomatic protest behavior is a sign of the child’s dependence from an adult who imposes the rules. An enormous focus on the adult is maintained and the child can not reach the desired autonomy.

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Focal Play-Therapy

Following the Gestalt theory, Focal Play-Therapy (FPT) has been planned as a psychotherapeutic method for the treatment of eating and evacuation psychosomatic protest behaviors in preschool children (G. TROMBINI 1969, 1970).

Basically, this therapeutic approach consists in the proposal made by the therapist of a temporal sequence in which the main character is a plasticine puppet guided by the therapist who performs basic physiological functions (eating, evacuation, sleeping). These functions have a primary importance for preschool children. The therapist gives his/her voice to the puppet making it talk about and ask for foods that are prepared with the same materials (plasticine) and that the puppet shows to appreciate. After eating, the puppet expresses the need to urinate and defecate in a potty or toilet bowl built with plasticine. This is followed by relief and comfort exclamations.

The therapist acts in a reference system which shows the natural and phenomenal properties of food and corporal contents as “something to put inside” and “something to eliminate” respectively. According to Kurt LEWIN, the therapist tries to re-establish food and corporal contents “valence” (*Aufforderungscharakter*) suggesting a direct contact with them through food selection, food preparation, eating decision, the need to evacuate and the desire to do it in an appropriate place for the family. The therapist defines the meaning of these functions, integrating eating and evacuation as parts of the same process. In this way, eating and evacuation contents clearly appear in their natural aspect. The focus is on the phenomenal qualities of these stimuli and the child driven by the motivation to do by oneself feels the desire to build a direct and independent contact with them. Therefore the child is able to internalize the relationship with them as it has been represented by the therapist. In this way an alternative reference system to that proposed by the family in which adults interfere with self-regulation processes (METZGER 1976), such as eating and sphincteric control, is given to the child.

The adult should allow the child the freedom to decide; otherwise food could be interpreted as something to refuse or, as in the present case, to vomit. Corporal contents could be configured as something to give as a present or to withhold in response to adult demands. Afterwards the therapist withdraws into the background allowing the child to externalize in the play his psychological contents, intervening when appropriate, with simple interpretations referring exclusively to the play events or with suggestions regarding possible alternative solutions to the play events.

Focal points of this method consist of highlighting independence features in the relationship with food and evacuation functions and in allowing the child, through the identification with the plasticine puppet, to face the repeated and uncertain experiences of taking and giving, also surpassing the anxiety for the loss of corporal contents. Moreover this method allows the expression of aggressive experiences without the fear of altering the relationship with the adult. Therefore spontaneity, support and collaboration are promoted. The therapeutic situation can become a place of creative freedom where new and unexpected solutions can be born (WALTER 1977).

The restriction to do by oneself, for example through insistences on eating or through unwanted impositions of the adult, could cause an enormous focusing on the

same adult. In this case the child refuses eating and evacuation and, although expressing his effort to break free from the reference adult, he is not able to re-construct a normal relationship with food and corporal contents and to reach the desired autonomy. The FPT enables the child to re-establish the natural focusing on these contents and the direct expression of the motivation to do by oneself. Moreover, it offers the child the opportunity of externalizing and developing features, particularly aggressive aspects, related to its own situation: these features become play subjects that gradually find a non controversial resolution.

This resolution benefits from the appropriate internal structure of the therapist as a consequence of his/her acquired psychodynamic competence in relation to both the comprehension of the nature of intrapsychic and interpersonal conflicts and to the ability in developing stories together with the child (FERRO 1992; VALLINO 1998; FERRO & BORGOGNO 2000).

Finally, when an active participation associated with a spontaneous drive to develop the entire eating-evacuation sequence has stabilized in the child, psychosomatic protest behaviors can be observed. It is a signal of a reduction of the infant narcissism in favour of the increasing feeling of "We" and of significant social relations.

The adoption of this method in clinical practice has shown the opportunity for the child to find features already experienced in relation with the therapist within the family context. This allows the child to feel in contact with his parents (primary aim of all psychotherapies), perceiving their attitudes both pre-existing to the treatment but unnoticed or appeared during the therapy, as appropriated. In this way the child can feel like an effective member of the small family group. A healthy psychological development allows the child to feel an effective member of his family. To achieve a reciprocal continuous communication, the child receiving the same esteem as the other members and having a recognized and accepted role in the family are essential elements. These factors allow a harmonic communal life which is the criterion used to define the concept of socialization from a psychological view: if the child is well inserted in the family context it will develop without constriction the impulse to become part without conflicts of the system (METZGER 1976).

Focal Play-Therapy in the extended child-parents context

In the history of infant psychotherapy parents have for a long time been left outside the psychotherapist's room. It has been a defensive strategy to enable a close relationship as soon as possible with the child and to avoid an emotional involvement with difficult family feelings. The FPT was created during that period. Often it has been noticed that it was natural and sometimes necessary to receive, during the first psychotherapeutic sessions, the adult (usually the mother) together with the child. The modern view on psychotherapy has changed. Nowadays, receiving the child together with his parents, even if with different modalities, is rightly considered essential. Consequently, it has been proposed to conduct the FPT in an extended context utilizing parent competences and giving value to their presence instead of excluding them. It is a potentially positive integration to the psychotherapeutic process in which the possibility to get close to his parents and to try to solve his problems, is given to the child.

The therapy is organized into alternating sessions with parents and child together and sessions conducted only with parents. Central to the setting is the demand made to parents to pay attention to their child's behavior and play, with the aim of later discussing it with them without disturbing the child. It must be underlined that the FPT in this extended context still remains a psychotherapeutic method exclusively for the child and not a family or parents therapy. It is an opportunity for the child to talk about the self in the presence of his parents and for parents to talk with him, according to the model proposed by VALLINO (2002) in the *Participated Consultation*. It follows that finding the way to help their child gives relief to parents, in close contact with the child, re-examining their parental competence.

This gives the child the opportunity to face the problems with his family group which is the primary source of both well-being and pain. In this way a new context is created in which the child can experience his competence as an independent and convivial person and at the same time he can find a way to let his problems be understood by others. Moreover, this extended context allows the parents to understand through play participation the psychological aspects behind eating and evacuation behaviors and to favor family harmony through appropriated interventions.

A clinical experience of Focal Play-Therapy in the extended parents-child context: The case of Marzia

First therapy session: parents²

Marzia's parents contact the therapist because their two years and three months old daughter shows eating problems: Mz has never eaten much, usually the same food, she is suspicious of new tastes and recently she is vomiting during meals. The parents are young, both are clerks and Mz is their only child. She is a premature baby and she was born at 35 weeks with a weight of 1600 grams.

During the first part of the session the parents spontaneously give anamnestic information about their daughter, complementing each other and focusing particularly on meal moments and modalities. During her first 6 days of life Mz has been parenterally fed because of her premature birth and during the first months breast feeding was very difficult. The weaning succeeded late when Mz was 10 months old. She has been attending day nursery since she was one year old where she remains till after lunch. During the afternoon she stays with her grandparents until her parents come back home around 6 p.m. Her lunches at the day nursery are regular and the vomit appears only when she is at home. The father (F) says: "she doesn't eat and she is not interested in new food, only when she is at home". The mother (M) says that sometimes she could strangle her because Mz eats a little bit and then she doesn't want to eat anymore: "when pressed she eats a little bit more but then she closes her mouth, sometimes she spits the food out and frequently she ends up vomiting".

² In the description of the sessions the therapist (T) will talk using the first person.

I ask them to describe her. They say that Mz is normal weight, she is lively and well. When she comes back home from the day nursery she has a 300-gram bottle of milk, then another one as an afternoon snack and another one before going to sleep because she often doesn't want to eat for dinner. F: "according to the pedagogist of the day nursery Mz expresses her problems with us through her eating behavior while according to the paediatrician her vomit is a consequence of mucus that stores in the respiratory airways and so when she goes to sleep with her bottle of milk she coughs and vomits". M is particularly worried since she recently saw Mz playing with a puppet and making it play and then vomit in the bin.

Recently Mz asked her mother why the other children eat without vomiting. A paediatric examination has excluded any organic cause for the vomit and growth consequences.

T asks them if they have any idea about the possible causes of their daughter's vomit. M: "the vomit has become a habit for her, sometimes she even tries to vomit". F: "I don't agree with you, Mz doesn't like vomiting, she doesn't do it on purpose, it is a consequence of the mucus." Parents ask me how to behave: should they get angry with their daughter or should they try to calm her down? Sometimes as a consequence of her eating problems they disagree with each other and argue "and our child suffers from this". At this moment I don't answer their question and I just let them notice that drinking so much milk is a typical feeding habit of a very young baby. M agrees: "everything is so difficult. Even going out is a problem. I can't go to restaurants because Mz only wants milk and babyfood. She eats just to survive, she just wants to play and she is also suspicious of other."

I rapidly explore the other development areas coming back later to play area that parents introduced. Mz hasn't got any sleeping problems, she sleeps in her bed and she started talking when she was around one year old and now F says: "she tells you things"; "if she wants" M adds.

She still uses nappies: parents tried potty training but she didn't show any interest and they didn't insist. Her integration at the day nursery was quite good even if during the first days she cried a little bit; "she was the smallest one" and during the first months she didn't eat but now it is going better, she is glad to stay there and she plays with her friends. I ask which kind of games she likes to play. M: "small pans, puppets, she likes reading her books. When we come back home in the evening she runs around the home in a crazy way, she needs to run around and we let her do it. Mz. plays repetitive games in which she involves all the family. She has her rituals: the puppet does the shopping, it eats, and then it goes to the hair dresser and she doesn't want me to do things in a different way.

In the evening we are totally dedicated to her, even if I have a lot of things to do I can't disappoint her, maybe she is a little bit spoiled but she is the only grand-daughter and we are the only children".

M. adds: "I'm worried that she could become anorexic as a consequence of her conflict with food and because of our insistence". F.: "Mz. has clear ideas; one aunt offered her some pizza and she answered: eat your pizza and I'll do what I want. If she says no it is no".

At the end of the session, selecting some of the contents which emerged, I suggest to the parents to examine the possibility to adopt a more permissive modality to propose

food without forcing Mz. and to try to make her stay at the table with them during the dinner which is an important event to share together. It could also be possible that the bottles of milk satisfy her so much that she doesn't feel hungry at dinner time.

They can help their daughter to have a better diet appropriate for her age choosing snacks that she likes and reducing milk. M. agrees also thinking about Mz. admittance to the nursery school next year.

Thinking about Mz.'s games with her parents M. says that Mz. always does the same things, she makes small plasticine parts and she sticks them everywhere. T: "sometimes it is difficult to understand the meaning of her game, you can feel bored and not very involved. It could be helpful having moments in which you don't play all together but in which each of you separately make a game with Mz from the beginning to the end to have fun together to understand better what is happening". F: "so we should let her guide us". M: "she doesn't want to be guided by us!" I tell them that during this period we can focus on the things we have spoken about, particularly about eating and play modalities. We fix another session with their daughter too.

The emotional atmosphere of the entire session is quite relaxed: the parents seem a little bit like children themselves who need some practical suggestions about how to proceed, proving their parental ability.

They seem to me to be quite capable parents: the M. is more severe and self-critical but also less "superficial" compared to her husband.

Scenic analysis of the first session

The scenic analysis is a phenomenal method based on the Gestalt approach (WERTHEIMER 1945; GALLI 1988) which tries to understand both the general qualities of the observed event and the qualities of its specific event parts, particularly the roles interpreted by the different actors in the action sequence.

From the parents' report some scenes emerge.

The first scene shows Mz. as an active wild child ("she runs around in a crazy way ... we are totally dedicated to her"), as a small tyrant who subjects her parents to her desires, trying to fulfil her freedom feelings in the play area.

The second scene takes place at the table: "Mz. eats a little bit but afterwards she doesn't want to eat anymore" and this makes the parents argue about better strategies to use and about the meaning of her vomit. Mz. seems unable to play the role of "table-companion" (M. says that she just eats for survival and her way of eating is not of that of a table-companion, she also would like to go out with her daughter for dinner). The parents are worried about their daughter's health, they have already been worried in the past because of her premature birth, and therefore they force her to eat. Mz. is frustrated about not reaching her own independence in the eating area.

The third scene happens in the evening before going to sleep when Mz. drinks her third bottle of milk. It is a regressive behavior probably favoured by the parents to deny their pain related to the premature birth trauma. At the same time this behavior is accepted by Mz. influenced by the worry to lose her parents love.

The therapist makes them notice that from an eating perspective Mz. is treated like

a baby. In this way she makes clear the contrast between the baby and the table-companion and suggests a different eating modality to the parents who assuming the role of children in need of suggestion happily accept. The relationship therapist-parents can be described in terms of a hierarchical structure (“Treppenstruktur”, METZGER 1982).

Second session: Marzia and her parents

When I first meet Mz. she is sitting in the lobby with M. She is thin but has a lively and expressive aspect. I exclaim: “There’s a child here! What’s your name? (Mz. says her name). We have a room full of toys, do you want to come to see it with your mother and your father?”

Mz. looks at me carefully, staying close to M., who keeps silent and smiles, then without the slightest hesitation she makes for the stairs with me, followed by her parents. She doesn’t want to be helped to go up the stairs although her parents watch her from behind. As soon as we go in the room her parents tell me that things are going much better. Mz. takes the toys off the table and looks at them, she’s interested in them, she doesn’t look suspicious. Mz. takes the plasticine and says that it’s hard. T. “if you want I can soften it to play with”. Mz. accepts and makes a small snake. M. participates inviting her to make eyes for the snake. F: “Mz. likes making pizza, don’t you? What do you like making?” persisting until Mz. answers “pizza”. Mz. is kneading the plasticine and I ask her: “Would you like to make a puppet?” (thinking to the FPT sequence). Mz. accepts delighted and names it “Pippo”. F.: “Pippo has feathers because it is the name of a puppet that we have at home” and he goes on drawing an analogy with a swan at the park that you don’t have to touch because it pecks. Mz. moves away and goes to the small wooden home. She takes the puppets and says: “they all are children”. She makes one puppet go up and down the stairs singing. By going up the stairs I think that she is expressing through play her desire to be independent and I comment: “He’s great at going up the stairs!”.

During this play sequence F. asks Mz. about her name, her home address, about what she should tell in case she gets lost. The child answers in a fixed accelerated but charming way. Puppets are in the bed and F. proposes to give a belly rub. Mz “no, they have to go to sleep early”; F.: “ but when you go to sleep you want to have massages”. So Mz. lies flat under the table; M. asks her to come out but she doesn’t move and she says that she is staying in bed. T. waits a little bit then taking the plasticine puppet asks: “May I come and stay in bed with you?” Mz. smiles: “mum look the puppet is sleeping with me!” Mz. comes out from the table with Pippo and we start to play on the table again. I suggest the FPT sequence (eating-evacuation). We make meatballs to give to Pippo so when he is full he goes to poop. Mz. actively participates, at the beginning she just observes then she cooperates proposing the play sequence. Mz. proposes that Pippo after having evacuated goes to sleep. Then she asks if she can make a friend for Pippo: Pippino. The eating sequence goes on and M. offers to make plates and forks which Mz. accepts with pleasure. F. stands up, looks at the doll’s house and then sits down again. He isn’t able to take part to the play instead the M. is involved. During the play Pip-

po's plate falls down, Mz. looks at me, I pick it up and I give it to Pippino but Mz. says that Pippino doesn't want to eat anymore because he is angry. T.: "Pippino doesn't want meatballs because they have fallen down and aren't good anymore; he's right to be angry". Mz.: "he wants his babyfood, now he wants to poop". T.: "his belly is empty, how can he poop?". Mz.: "Now he isn't angry anymore, he wants to eat and then to poop".

So M. makes a new plate for Pippino and the eating-evacuation sequence is completed until sleeping. At the same time F. looks around inattentive. Mz. looks at her hands which are green because of the plasticine. T.: "my hands are green too, it's because we have played". Then M. shows her hands are green too and smiles.

Mz. turns to F. whose hands are white and so she soils his hands with her hands and he smiles. Then she wants us to go all together to the bathroom to wash our hands.

Before ending the session F. tells me that after our first session Mz. did not vomit anymore: "I would have liked to talk about this, I don't know what kind of miracle happened". I tell him that next time we will talk about it and that maybe our first session has helped them. F. "Mz. doesn't know that we met!" I tell him that children easily understand when the family context is different, when it's more relaxed.

Scenic analysis of the second session

The session is generally characterized by *playing together - having fun together*. Let's analyze the role of each of the three adults participating at the session.

The mother is involved and gets into the play mood, always supporting everything that is happening. The father comes in with a series of distracting speeches, wandering off the point (make pizza, analogy with the swan, her name, massages) until he cuts himself off. The final trick of Mz. consisting in spoiling her father's hands and inviting everybody to go to wash their hands as a way to form a group is extraordinary.

The role of the therapist consisted in establishing early an alliance with Mz. (from when they went up the stairs) and then presenting to her play sequences (FPT) with attractive valence (according to LEWIN) strictly related to her desires. Moreover she favored the parents participation proposing a cooperative structure ("Ringförmige Struktur" METZGER, 1982).

It should be underlined that during the therapeutic session Mz. played the FPT eating-evacuation sequence entirely, understanding and accepting the basic rules of physiological processes related to eating and evacuation (you can't evacuate without eating before).

Third session: parents

Today F. confirms that Mz. stopped vomiting and according to him it is due to the fact that they are more calm, they followed the suggestion of not continuously giving her bottles of milk and agreeing that their daughter shouldn't be completely filled like a premature baby, but they should let her feel hungry before meal times.

It seems that the parents following my practical suggestions assumed the role of “good children” in front of me.

Instead, it’s important to help them improve their parental abilities in observing their daughter, for example in the shared play area.

Therefore I express my happiness to know that the eating behavior at home is getting better and I tell them that now it’s important not only to think about what happened at home but also about what happened during the past session when we all played together.

M. notices a sort of similarity between the games they played during the past session and the games they usually play at home: small pans, baby food, plasticine which she really likes. M. says (happy) that Mz. had a lot of fun here and that she has seen her particularly relaxed “it’s strange because usually at first she wasn’t like that”. F.: “doctor, you played special games which really involved Mz.; it’s clear that you are experienced and able to play with children (with an admiring tone).

My wife and Mz. like to play with plasticine a lot while I prefer to play with Mz. on our bed or to go out with her”. T.: “plasticine games played with Mz. concern the eating theme which was her main problem. For this reason these are games very important and pleasant for her. You have been very good in following her and in presenting games with diverse modalities to play”. I go on telling them that maybe F. is trying to underline that sometimes it is not easy to play if you don’t understand the game (plasticine, small pans) or that when you play all together it is difficult to play a specific role inside the group.

I refer to what they told me during the first session and what happened today: when the parents go back home in the evening they play all together with Mz., sometimes also the grandparents play with them, the child proposes games “flitting” from one to the other and dictating the rules and sequence (“now do that!”).

I tell them that in these situations you can easily feel a bit of a performer losing the play sequence and enjoyment because nobody is ever completely involved in their role. Parents understand me and we end the session talking about the importance not only for Mz. but also for each of them of having some “exclusive” play moments besides group play moments.

These moments are important because you can observe what Mz. is suggesting, you can intervene proposing your own thoughts and preferences so as to go on with the couple play, feeling involved as a couple and creating the possibility of having fun together.

Scenic analysis of the third session

The beginning was characterized by the parent’s satisfaction and gratitude. It is followed by the therapist intervention of drawing attention to the game they played during the past session. At this point parental roles are differentiated. The mother’s role is focused on the play features while father’s role is focused on the therapist.

Although recognizing the efforts made by both parents, the therapist’s intervention underlines the difference related to their different ability in understanding the game and the difficulties in finding their own role in a group play. For this reason the therapist proposed couple games.

Fourth session: Marzia and her parents

When Mz. sees me she hides behind M. and F. has to hold her in his arms to enter: “today Mz. feels shy: Mz. has something to tell you!”. Mz. smiles coyly but doesn’t talk. F.: “do you want to tell her that you are going to have a brother?”. I smile and I compliment. Then I say that it doesn’t matter if Mz. doesn’t want to talk about it. Mz. goes immediately to take the plasticine puppets in her box. We distribute them on the table, Mz. looks at them and I invite her parents to play and I draw in the background. F.: “M. is good and creative, I’ll make a small snake as usual”. Mz. starts an eating-evacuation sequence similar to the sequence of the previous session with M. preparing dishes and F. participating more than in the past session. I let parents play with Mz. and it happens without any hitches. During the puppet eating sequence, Mz. puts some plasticine in her mouth saying: “always in mouth!” and M. says with a reproaching expression but smiling: “and what do I tell you?”. T.: “plasticine is not good for children but it is good for a puppet”.

Mz. puts the puppets to bed because they have to go to the nursery school. M. makes a blanket for the puppets and then says that the day after they could go out for a pizza. Mz. specifies “no, spaghetti”. So the play goes on. F. offers to tuck the puppets up and to give them a belly rub as they do to Mz. Mz.: “they woke up”, they eat and then she makes them poop and pee on the toilet (asking for my help). Then she puts them to bed again. She goes on giving them the bottles of milk and food and she asks M. to make spoons. They play together. Then the puppets go out and F. suggests making shoes and hats for them.

While they all play together in harmony, sometimes F. refers to Mz. (Let’s do to the puppets what we do to you?) but Mz. doesn’t answer. She takes a penguin and she throws it noisily on the floor. M.: “Today you are being destructive!”. T.: “Mz. wants to make noise!”. Mz. throws the penguin on M. T.: “do you act in this way when you are angry? When you are angry you make noise, you scream and you stamp your feet”. Mz. looks at me amused. F. stands up and goes to the doll’s house followed by Mz., who takes the puppets. Together they lay the table and they feed the family, then Mz. wants to put them to bed.

T., who already told Mz. that this would have been their last meeting, adds: “now that you have arranged everything so well, would you like to take Pippo and Pippino home with you?” M. agrees. We put the plasticine puppets in a box so that they can play with at home.

Scenic analysis of the fourth session

At the beginning of this session the therapist draws back in the background letting the three play together.

The father seems to be more “tuned in” even if he continues coming in with distracting speeches in a way to establish a direct couple relationship between him and Mz. The mother makes some drastic interpretations (maybe she plays psychologist).

The therapist moderates these interpretations focusing merely on the description of what is happening (make noise vs destructivity). Mz. seems to be independent, sometimes she acts in a challenging way (plasticine in her mouth) and she doesn’t want her mother’s intervention on her body.

The general impression is that parents are now more able to form an alliance with their daughter’s initiatives. Moreover regarding the eating area a natural focus on food and a pleasant contact with them has been re-established within a harmonic family context.

Fifth session: parents

It is the restitution session, postponed by the therapist because of her personal problems. In the meanwhile there have been phone calls.

M. announced that she is expecting twins: “at the beginning I was scared, remembering my pregnancy with Mz. After our sessions things are going well, with Mz. and food, she hasn’t vomited anymore”.

M. and F. come with pastries. M is beautiful, she is six months pregnant. She says: “I feel good because I am at home” (she just spent a month holiday at the sea with Mz. and her grandparents). I ask how the month has gone with Mz. She says: “well but she is wild (F. nods too), she was always outside in the courtyard with older children who played hide-and-seek. She ran around but I don’t know if she understood ... but she ran around with them. The last week I was exhausted, fortunately the grandmothers were with me”. I ask how Mz. reacted to the twins news. F: “well, when we told her that there were two of them she looked at us intensely, it was clear that she was thinking it over. Now she gives us kisses but she also slaps her mother’s belly”. I say that it’s normal and it’s a good thing: Mz. can express her conflicting feelings because she feels that her parents can tolerate them.

F.: “Mz. is doing well also with food”. The child still drinks some bottles of milk but they don’t replace food. M.: “for the last three months she wants to eat cutlets and when we were at the sea she asked for ice cream”.

F.: “we also started to potty train her; sometimes she remains dry and she tells us when she needs to pee but other times she starts peeing before and then she says it”. At this point I feel it’s useful to underline some aspects of this argument: 1) their ability to have a good relationship with Mz. consists in proposing without forcing her; 2) it is possible that during the development course to the acquisition of the sphincteric control she may have a pause moment when her brothers are born. F.: “will she regress?”. T.: “it is not a regression but just a reflection moment because the acquisition of the sphincteric control which goes from the second to the third year of life is strictly related to personal events”.

We talk about the two months left until the birth. Parents talk about their programmes in the case they will have to spend some days in Neonatology. M.: “I already know the environment and the doctors”. T.: “it’s a good way to think about the event like Mz. does telling us that she will wash her brothers as she does with her puppets (parents just told me this). It’s important for you and for Mz. to get ready for the event thinking how it’s going to be when the babies are born. It’s also important to get Mz. involved in the babies nursing with M. (for example letting her wash their feet) and also nursing Mz. with the babies (during babies breast feeding give Mz. her bottle of milk keeping her close to them). You can also think about a game-present that the babies bring for her”.

Parents express their gratitude for these suggestions and tell me that they feel held and supported.

Afterwards M. called me to tell me about the twins’ birth: “Everything went well, there were no complications. At home everything is going well too. Mz. is happy even if sometimes she is a little bit jealous”.

Concluding remarks

The FPT offers a setting with specific rules: first you eat then you evacuate. It offers a sense of order both regarding body functions and the integration of infant self-regulated and self-managed behaviors in a harmonic communal family life.

The FPT in an extended context takes account of both the child's demands and the parent's need to be re-evaluated in their parental abilities. Parents can take the opportunity to understand the child's interests expressed through the play and also its way to non-verbally express its desires, fears and angers.

A child who refuses food is no longer considered by the therapist a mere body-organism that needs to eat and is risking its health. The eating behavior is not only considered at a concrete level. Now it is possible to give to it a psychological interpretation. Thus the context favours the respect for the child's way of playing and the possibility to play with it without assuming directive and intrusive positions.

Parents, encouraged to become players, have the opportunity to experience their play ability and feel a pleasant participation.

Taking part in the play parents can focus on what is happening, also using their fantasy. They can retrieve their infant playing and creative Self and the observant aspects of their adult Self.

Of course this can happen when parents already have these personal abilities. In this way the play can become a common play and the pleasure of sharing can help find the psychological aspects related to eating and evacuation physiological functions without considering only the body well-being or indisposition problem.

Indeed the FPT in an extended context allows the child to notice their parents constructive behaviors emerging during the therapy.

At the same time parents look at their child's transformation and can understand that this transformation happened also because of their active collaboration, primarily of their comprehension of their child's needs.

The extended context also allows the therapist to observe if parents obstruct or block the play development with intrusive behaviors or comments which aren't involved in the current narration and expression of personal problems.

Other clinical cases show that the short course of sessions (that was adequate in the present case) hasn't only got a therapeutic function but also an evaluative function regarding a possible continuation of an eventual psychotherapeutic treatment prosecution.

Sometimes psychosomatic protest behaviors need a longer treatment. The observation of the child-parent interaction and analysis of the parents' behavior can give information about the chance of going on with the FPT in the extended context or of starting a new form of psychotherapy.

The FPT is based on an organized starting point that is proposed by the therapist after an initial friendly and warm contact. This organized starting point, guided by the Gestalt theory, can be found also in other therapeutic approaches. For example, the actual infant cognitive psychotherapy supports the opportunity that the therapist intuitively perceives the clues of the needs expressed by the child favouring a perceptive focusing on them (LAMBRUSCHI 2006).

The psychotherapeutic technique used here is based on an organized starting point that allows the child to express the motivation to do by oneself, part of the basic exploratory-assertive motivational system, in a self-regulated behavior that increases the alliance with parents and the family group integration (LICHTENBERG 1989).

The FPT privileges the development of a good emotional background because the classic insight can not be used with preschool children who have not yet developed this ability (SUGARMAN 2003). The child, understanding that the therapist is interested in it, is encouraged in becoming interested in adult mind and interactive modalities. This favours the alliance with the child and its parents and particular attention must be given to this alliance.

Summary

Following Gestalt theory, Focal Play-Therapy (FPT) has been planned as a psychotherapeutic method for the treatment of eating and evacuation psychosomatic protest behaviors in preschool children that are thought to be a consequence of the frustration by the parents of the motivation to do by oneself.

Focal points of the FPT consist 1) in highlighting independence features in the relationship with food and evacuation functions; 2) in allowing the child to face and to surpass the anxiety for the loss of corporal contents; 3) in allowing the expression of aggressive experiences projected on food and corporal contents. The present work shows the use of the FPT in the extended child-parents context as a way to take advantage of parents' abilities. This integration favors the therapeutic process 1) giving to the child the opportunity to get close to his parents who are trying to solve his problems; 2) giving to the parents the opportunity to understand, through the play participation, the psychological aspects related to eating and evacuation behavior, also favoring through adequate suggestions a harmonious communal family life.

Zusammenfassung

Auf der Grundlage der Gestalttheorie stellt die Fokale Spieltherapie eine psychotherapeutische Methode für die Behandlung von psychosomatischem Protest-Verhalten in Form von Essstörungen und Störungen der Defäkation bei Kindern im Vorschul-Alter dar. Diese Störungen können als Folge der Unterdrückung des Drangs zum Selbermachenwollen aufgefasst werden.

Folgende Aspekte stehen in der Fokalen Spieltherapie im Vordergrund: 1) In Bezug auf Ernährung und Entleerungsfunktionen wird der Aspekt der Autonomie hervorgehoben; 2) Den Kindern wird die Möglichkeit gegeben, sich mit der Angst vor Verlust von Körperinhalten zu konfrontieren und sie zu überwinden; 3) Es wird ihnen erlaubt, aggressives Erleben, das auf Nahrung und Körperinhalt projiziert wird, auszudrücken. Die vorliegende Arbeit zeigt den Einsatz der Fokalen Spieltherapie im erweiterten Kind-Eltern-Kontext als Möglichkeit, die elterlichen Kompetenzen für den Prozess zu nutzen. Diese Integration fördert den therapeutischen Prozess, indem sie 1) dem Kind die Möglichkeit bietet, sich den Eltern, die im Spiel als Verbündete fungieren, anzunähern und 2) den Eltern durch das Mitspielen Einsicht in die mit Ess- und Entleerungsverhalten zusammenhängenden psychologischen Aspekte ermöglicht und somit die Verständigung innerhalb der Familie fördert.

References

- ARFELLI GALLI, A. (1995): L'evoluzione del Sé. Problemi e metodi, in AA. VV., *L'evoluzione del Sé. Teoria psicologica e prassi educativa*. Assisi: Cittadella Editrice.
- BALDARO, B. (2002): Enuresi ed encopresi: segnali di crisi sulla strada dell'autonomia, in E. TROMBINI (a cura di), *Il dolore mentale nel percorso evolutivo*. Urbino: QuattroVenti.
- BALDARO, B., TROMBINI, G. (1989): Disturbo del controllo degli sfinteri, in M.W. BATTACCHI (a cura di), *Trattato enciclopedico di psicologia dell'età evolutiva, vol. 2, tomo 2*. Padova: Piccin.

- BALDARO, B., TROMBINI, E., TROMBINI, G. (1994): I sintomi psicosomatici dell'evacuazione come segnali di crisi psicologica nell'infanzia, in G. TROMBINI (a cura di), *Introduzione alla clinica psicologica*. Bologna: Zanichelli.
- BATTACCHI, M.W., GIOVANELLI, G. (1988): *Psicologia dello sviluppo*. Roma: La Nuova Italia Scientifica.
- CANESTRARI, R., TROMBINI, G. (1975): Psychotherapie als Umstrukturierung des Feldes, in S. ERTTEL, L. KEMMLER, M. STADLER (Hrsg.), *Gestalttheorie in der modernen Psychologie*. Darmstadt: Steinkopff.
- FERRO, A. (1992): *La tecnica nella psicoanalisi infantile*. Milano: Raffaello Cortina Editore.
- FERRO, A., BORGOGNO, F. (a cura di) (2000): *La "storia" e il "luogo immaginario"*. Roma: Borla.
- GALLI, G. (1988): *La Psicologia tra rispetto e sospetto*. Bologna: CLUEB.
- KEMMLER, L. (1957): Untersuchung über den frühkindlichen Trotz. *Psychologische Forschung* 25, 279-338.
- LAMBRUSCHI, F. (2006): Il bambino. In B. G. BARA (a cura di), *Nuovo manuale di psicoterapia cognitiva. Vol 3, Psicopatologie*. Torino: Bollati Boringhieri, 83-123.
- LICHTENBERG, J.D. (1989): *Psychoanalysis and Motivation*. Hillsdale New Jersey: The Analytic Press..
- METZGER, W. (1959): Die Entwicklung der Erkenntnisprozesse, in: *Handbuch der Psychologie 3, Entwicklungspsychologie*. Göttingen: Hogrefe.
- METZGER W. (1976): *Psychologie in der Erziehung*. Düsseldorf: Kamp.
- METZGER, W. (1982): Möglichkeiten der Verallgemeinerung des Prägnanzprinzips. *Gestalt Theory* 4, 3-22.
- SUGARMAN, A. (2003): A new model for conceptualizing insightfulness in the psychoanalysis of young children. *The Psychoanalytic Quarterly*, LXXII, 2, 325-355
- TROMBINI, E. (2002): *L'opposizione infantile. Ostinazione e protesta psicosomatica*. Padova: Upsel Domeneghini Editore (Quaderni di Scienze dell'Interazione, 2).
- TROMBINI, G. (1969): Sull'esistenza e comparsa della motivazione a fare-da-solo nel campo alimentare ed evacuatorio, *Rivista di Psicologia* 2, 111-131.
- TROMBINI, G. (1970): Das Selberrmachenwollen des Kindes im Bereich der Ernährung und Entleerung. *Prax. Kinderpsychol.* 19, 1-10.
- VALLINO, D. (1998): *Raccontami una storia*. Roma: Borla.
- VALLINO, D. (2002): Per una cultura del legame mentale tra genitori e figli. In E. TROMBINI (a cura di), *Il dolore mentale nel percorso evolutivo*. Urbino: Quattro Venti.
- WALTER, H.-J. (1977): *Gestalttheorie und Psychotherapie*. Darmstadt: Steinkopff.
- WERTHEIMER, M. (1945): *Productive thinking [Chapter seven: Two boys play badminton]*. New York: Harper and Brothers.

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