BOOK REVIEW

David Smyth. (2013). Person-Centered Therapy with Children and Young People. London: Sage Publications. ISBN 9 78057 027603

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Introduction

In his introduction to child-centred therapy in Chapter 2, Smyth feels that it is now time to give child-centred therapy its rightful place as a full member of the person-centred group of therapies. At any point in their lives, all people - irrespective of age - embody the sum of their experiences: personal; relational and environmental. As human beings, we 'accumulate' experiences and try to find a way of placing those events within a context that may permit us to continue with our lives. These experiences contribute to our individuality and have the capacity to influence the paths we might take. Occasionally, childhood experiences can be so traumatising that the events remain inaccessible to the adult conscious mind. Nevertheless, even if events cannot be cognitively recalled, they can profoundly influence an individual's capacity to make and maintain relationships. In other instances, there may be only a fragment of conscious memory available to an adult in relation to a painful childhood experience.

Even before undertaking research for this book, David Smyth had come to believe that person-centred therapy had been developed, characteristically, as an approach to facilitate therapeutic work with adult clients. He felt concerned that his early training, founded on adult psychotherapy practice, would not enable him to offer therapy to children and young people. It seemed as if the person-centred approach was unsuitable for young clients, especially since it was popularly described as a 'talking' therapy. How could children be 'made' to talk when this was unlikely to be their communication method of choice? Little did he then appreciate that children can comfortably converse within a therapeutic relationship using a form of communication called ‘play’.

This book is for students of counselling and qualified practitioners in other helping professions wanting to extend their training and thereby to contribute to their ongoing professional development. The author hopes that this volume will find its way to trainees and professionals in other fields, such as medicine, nursing and other allied health professions. Student teachers, trainee social workers, law officers (such as those working in the family courts) and others may find something here to enhance their professional and personal approach.

Organisation of the book

The book is presented in two parts, beginning with theory and practice and continuing with professional issues. Chapter 1 describes the person-centred approach for children and young people explaining the author's journey towards self-understanding. An introduction to child-centred therapy is provided in Chapter 2. Chapter 3 addresses associated child-related theories. Chapter 4 on the emerging child-centred practitioner identifies age as a cultural consideration and other cultural influences. Chapters 5 and 6 explain how the author developed his practice, including very sensitive professional interactions. Child-centred therapy for children with particular needs is addressed in Chapter 7. Chapter 8 examines directive and non-directive therapy. Chapters 10-13 in Part II of the volume, address professional issues. These include: receiving referrals and communications, boundaries in child-centred therapy, multi-professional practice and aspects of the law in child-centred therapy.

Chapter 9 of the book is of particular interest and provides a careful discussion of play materials and dialogue in therapy. Smyth examines the concept of play and a child's use of play as a means of communication. Play is universal in children and supports a child's cognitive development, socialization, physical abilities; in fact every facet of growth and development. Play is essential in children's ability to cope with stress and is a means of managing emotionally challenging experiences. He cites authors who describe the use of play as a therapeutic modality enabling children to express thoughts and feelings, assimilate reality, resolve internal conflicts, achieve mastery and cope effectively. True play is characterised by the child having ultimate control over play determining what themes or concepts will be explored to meet his or her own idiosyncratic needs or interests. Such play might also be known as child-centred or child-

directed play. Conversely, 'true' play cannot be realised if the adult controls the objects or themes or if specific time limits or expectations are imposed or if the play is adult-directed, for example, to impart specific concepts or knowledge.

Thesis of the book

Three conditions have come to be known as the 'core conditions' described in Chapter 2. Firstly, the therapist should be congruent in the relationship; secondly, the therapist should experience unconditional positive regard towards the person and thirdly the therapist should experience an empathic understanding of the person's internal frame of reference. However, the core conditions are meaningful only if *all* conditions are present. The first condition is congruence. The basic premise of the person-centred therapist is 'that of being transparent enough to perceive the world non-judgementally, as if the therapist were the other person, in order to accelerate the formative tendency of the other person toward becoming all that he or she can become'. Inspired by Carl Rogers, Smyth emphasises the need for empathic understanding. “In client-centred therapy the client finds in the counsellor a genuine alter ego in an operational and technical sense - a self which has temporarily divested itself (so far as possible) of its own selfhood, except for the one quality of endeavouring to understand.” In accepting persons for who they are, they in turn can become more nurturing of themselves.

Ideally, at the first appointment, nervous or uncertain patients will start to feel at ease. Here, Smyth strives to foster conditions that feel safe to them. A therapeutic relationship that strives to be equal requires that the therapist is open about the way therapy works. Patients who have an opportunity to understand the child-centred approach are likely to relate more confidently. Explaining the therapeutic model offers shape and texture to the therapeutic relationship. The description also allows them to relate explanations to their life and experience. These elements are central to therapy. 'How does this therapy work and where am I in all this?' Almost from the beginning, patients can begin to sense how they might feel in the process of therapy. There are times when, for instance, a child is understood to be quite anxious, Smyth will explain that we can readily understand some of these feelings. However, we may be unaware of other feelings that might be preventing sleep or affecting dreams and nightmares.

Patients are offered the opportunity to control and 'own' their personal emotional process and while they may not be ready to take control in the early stages of therapy, they will be aware that it is available to them when that time comes. The child's agreement to Smyth asking parents if they have any questions they would like to ask following the session is viewed as highly important. Parents may be able to provide the answers directly. When Smyth first meets with a prospective younger patient, he explains that he does not make assumptions or judgements about them. He explains to them that he has already met his or her parent(s) and that 'they told me all about you' without mentioning any difficulties parents previously identified that might embarrass or frustrate the child.

Associated child-related theories are explained in Chapter 3. A child needs a secure relational attachment readily achieved and maintained by loving parents. If a baby and young child has the love and company of his mother and soon also that of his father, he will grow up without an undue pressure of libidinal [attachment] craving and without an over strong propensity for hatred. Paradoxically, perhaps, aggressive behaviour also plays an important role in maintaining emotional bonds. Many of the most intense of all human emotions arise during the formation, the maintenance, the disruption and the renewal of emotional bonds.

Smyth explains that a child has the capacity to experience a range of senses and, if appropriately nurtured, these become a major resource for the child. It is a primal feature of the human condition that we have an unerring need to feel loved and wanted by those who are important to us. The nature of this love and wanting may undergo some adjustment as we grow older, but it remains with us. It is so powerful we will do almost anything to feel we are loved. Indeed, sometimes a child abused by a significant other may be convinced the abuse occurred only through loving intent.

A child's emotional development goes through an intensely formative period of major significance lasting some seven to ten years. Experiences can have a profoundly absorbent and enduring impact in adulthood. It would be inappropriate to attempt to define this by age with any accuracy, since it is highly specific and depends upon the conditions of each child's essential relationships. Smyth tentatively suggests that its duration could cover a child's experiences from about 5 years to the onset of his/her teenage years. By 'absorbent' in this context, Smyth has come to recognise that the significant life experiences and events occurring during this intense period of emotional development can have profound influence. It is as if certain events can 'skew' an individual's ongoing emotional growth, such that the impact of those events grows proportionately with the child into adulthood.

Chapter 5 is the first of two chapters on developing practice. Practitioners electing to develop experience in child-centred therapy should be prepared for the different kinds of endings they are likely to encounter. Smyth feels somewhat uncomfortable with formal endings in child-centred therapy, because he believes the patient process has not been brought to a conclusion; rather, it has simply been set on its way. It will hopefully continue to grow and, if the need arises, patients can ask to see him once again or someone else of their choice. Smyth describes that in his adult practice, it is not unusual for patients to renew contact after having been out of touch with him for a year or more. He describes how a girl whom he first met when she was 7 years old and how he saw her periodically as her needs determined, for the following nine years.

Therapy should help facilitate a patient’s more meaningful relationship with parents, friends and others in that patient's environment. If this occurs, there is a

decreasing need for the therapist's help and a gradual breaking off of the contact, with friendly interest still maintained, but no deep rapport. In such a situation the termination of treatment is decided as much by the child as by the clinician. It is a patient's reduced need for the relationship that will indicate movement towards the conclusion of therapy. This is an 'ideal process' that often may not or cannot occur. In these circumstances, it is important that the therapist can plan, in concluding treatment, 'to transfer the affect which the child has bestowed upon him to others in the child's environment'. It is therefore important for the practitioner to know, prior to the commencement of a patient's last session, that therapy is coming to an end. This will provide the opportunity needed by the therapist to bring the therapeutic process to an appropriate conclusion.

If, at the conclusion of a review, parents decide to discontinue their child's therapy, Smyth will seek agreement to a concluding session with their child, enabling him to talk to his patient about the review and in particular to explain the decision to bring therapy to an end. Whenever possible, it is important for practitioners to have a direct opportunity to bring the therapeutic relationship to a conclusion. Smyth invites us, for a moment, to consider the child's perspective. For example, the practitioner has a session with his/her patient when arrangements for the parental review are discussed, including reference to reporting back the outcome of this review. However, the patient and practitioner never meet again and the child is left wondering what has happened. Could it be that the practitioner saw the review as a way out of seeing the child again? 'Did I offend the practitioner without realising it?' These and many other questions may assail a child and this is why it is important to try to bring the therapeutic process to a 'natural' conclusion.

In Chapter 7, the author discusses children with particular needs, specifically mental health disorders. Bipolar disorder is well known to exist on a spectrum of severity and may be identified in children and young people who demonstrate exaggerated mood swings with perhaps periods of moderation between the 'highs and lows'. At the low end, children may experience severe depression and at the high end, they appear to be 'manic', perhaps needing little sleep, displaying an inability to sit still and showing unusually poor judgement for their age. Intellectual disorders make it hard for children and young people to absorb or express information and typically might include dyspraxia and dyslexia. Intellectual disorders can reveal problems with speech and written language, coordination, attention or self-control. Such disorders are usually assessed by educational psychologists and require the completion of a series of tests. More obvious disorders may be relatively easy to identify, but children and young people with mild affect, along with those who have the ability to conceal their difficulties, may not be identified and thus supported. Conduct disorder causes children and young people to act out their feelings or impulses in a destructive manner. Such problems may include lying, theft, aggression, truancy from school, setting fires and vandalism. Although these actions can be relatively minor at onset, they can become increasingly serious. It is considered that, generally, children and young people with conduct disorder have little concern for others and violate the rights of others and the rules of Society in general.

Eating disorders, as Smyth explains, can be life-threatening and include anorexia nervosa, bulimia nervosa and binge/comfort eating. Anorexia is associated with children and adolescents whose focus is centred upon a fear of gaining weight and who are invariably unable to recognise that they are in fact *underweight*. This condition generally affects more girls than boys, but there may be a tendency to overlook this condition in boys. Bulimia compels young people to eat and then rid their bodies of food by vomiting. Bulimia is defined as fear of fatness, while maintaining normal appearance and normal weight. In addition to the cycle of bingeing and vomiting, many female sufferers have irregular menstrual cyles, use laxatives excessively, have a feeling of lack of control over their eating behaviour and are persistently overly concerned with body shape and weight. The cycle of bingeing and vomiting can become well established and difficult to break. Anorexia and bulimia can be associated with excessive exercise, self-harming (see below), as well as suicidal and psychotic behaviour. Comfort eating occurs when children and young people use food to give them a feeling of wellbeing (during consumption) and may then be associated with self-loathing (following consumption).

Autistic disorder is a neurological disorder - children are born with it and the condition affects the way the brain develops. It tends not to be officially diagnosed until children show clear outward signs at around the age of three. Autism is a spectrum disorder and at any point along this scale children with this condition are prone to exhibit problems with social communications, such as lack of eye contact, difficulty carrying on a conversation and taking another person's perspective. Early intervention and appropriate therapeutic treatment can enable some children with autism to learn and function productively, but there is 'no cure' for the disorder.

Aspberger Syndrome (AS) which Smyth also considers, is a pervasive developmental disorder, the most distinguishing symptom being a child's obsessive interest in a single object or topic to the exclusion of any other. Children with AS are keen to know everything possible about their topic of interest and their conversations with others will be about little else. They may therefore tend to become isolated because of their poor social skills and narrow interests. Other characteristics may include problems with non-verbal communication and uncoordinated motor movements.

Smyth reminds us that the preferred likely means of communication for young children will be through the use of play and materials. It is also evident that people in their mid to late teenage years will prefer speech as their means of communication. Either end of this age communications continuum is relatively easy to define, but a challenge for the child-centred therapist is to offer conditions for the relationship that enable a child or young person to identify his/her personal preferences. It must not be assumed that a 14 year-old boy, for example, will prefer to engage in talking with the therapist rather than self-explore through

the use of activities. Equally, it is important not to take for granted that any child under the age of, say, 12 years old, will prefer to use play and materials. It is human to make judgements on a daily basis. Children and young people are no different, but practitioners need to transcend those conditions by offering conditions free of judgement and assumption. Experience and openness to new forms of expression enable practitioners to harmonise with individual patient preferences. A 13 year old might assume that the therapist expects him/her to talk as the basis for the relationship. In turn, an inexperienced child-centred practitioner might be tempted to assume that this individual prefers spoken communication. The experienced therapist takes nothing for granted on the age/communications spectrum and makes play and other materials available so that each individual can choose what will suit him/her.

From a child-centred perspective, Smyth believes key adults often have only a superficial understanding about the presence of resilience in children, who may convey to adults a sense that they can cope or are coping with significantly adverse events. His experience indicates that superficial impressions conveyed by a child towards - for instance - a parent, can be incorrectly interpreted as resilience in which the child appears to be largely unaffected by such events. In Smyth's experience, children can develop quite sophisticated constructs, including those aimed at appearing to others as though they are coping with situations that are in truth both complex and troubling.

In Chapter 10, Smyth explores ways of developing experience and emphasises the importance of providing suitable professional support. Safe practice involves practitioners identifying their initial limits of personal and professional experience and acknowledging an individual's capacity to build incrementally upon that initial experience. This needs to be carefully thought out and will vary according to the setting in which child-centred therapy is provided. Many organisations will have their own systems for considering and accepting new referrals. The guidance offered here defines the process from a private practice perspective and may include elements that might be appropriate for application in other settings. Establishing and maintaining effective communications with a patient's parents is regarded as worthwhile and beneficial in the developing therapeutic relationship. Finally, the chapter offers practical advice on the provision of refreshments to young patients and describes the recording of play therapy sessions.

The provision of boundaries is explored throughout the book. As well as providing a foundation for therapy these boundaries define acceptable limits while nurturing and facilitating patients. Practitioners have a central role, but patients also have a responsibility to the therapeutic relationship. In play therapy, the complexity is such that therapists need to be alert to a variety of layers that may be encountered in a typical session. Practitioners will be alert to ways in which patients may test the relationship.

Another subject which is addressed throughout the text is play and its importance; materials and dialogue in therapy. Art can offer independent indications about what is occurring for children in their inner and outer worlds. Painting and drawing gives credence to a child's inner creative urges and does not require spoken language. The therapist offers a child freedom to express and accepts the results as valuable to the child. Artwork can offer helpful insights in the context of what is already known about that child and may be significant for what is missing, inferred as well as what is represented. Viewing a child's chronological series of paintings or drawings on a particular subject can be enlightening.

Clay is a modelling material that comes in a number of forms. Smyth's preference is for nylon-reinforced clay - it is not too messy and can be used over and over again. Children can experiment with the material and there are no restrictions as to its use. They may create scenes, such as a living room, that can be intricate, laying the table and serving food, characters in a wrestling ring, a tropical jungle with wild animals. Possibilities allow children to explore with imagination and freedom - an activity they can do on their own or with the therapist, but it is important the child is in control. Asking the therapist to make a particular object and directing its shape, form and positioning, the therapist participates with the patient's consent, is observant of all stipulated requirements and carefully clarifies any ambiguity to ensure compliance with the child's directions.

Puppets have a variety of uses in symbolic play and as a therapeutic aid. When Smyth meets a young child for the first time, he may welcome that child with a puppet from his collection. It is an effective 'icebreaker' and rarely fails. His puppets are in essence a 'family' of different animals that have their own names and characteristics. Collections can comprise human figures, mythical figures, animals, *et cetera,* depending upon each therapist's preferences. A shy child may use a puppet to communicate with the therapist and a puppet can be effective as a 'go-between'. In this way, a child may cause the puppet to communicate with the practitioner using actions that reflect a wide range of feelings and by speaking in the manner of a ventriloquist. The conversation takes place between the therapist and the puppet. Children also use puppets for play that may seem quite rough and it is therefore important to choose puppets that are tolerant to rough handling.

Occasionally, Smyth decides to write a story for an individual child intuitively reflecting the child's circumstances, needs and emotions. The completed story will be given to the child with the suggestion that the story is read to him/her by a parent at a quiet time - perhaps at bedtime. The story is able to offer a means for interaction between parent and child. Many children spontaneously enter into dramatic play when they assign roles to themselves and the therapist. There was the 8 year old child who initiated a role-play activity in which she was the teacher and Smyth was the pupil. She was able to explore feelings around being in charge and what it felt like to issue instructions. Dramatic play includes all such variations! From mime to improvised acting, role-play, or a set play. Some children 'act out' when they let dolls or other characters take roles representing themselves and others close to them.

Conclusion

David Smyth considers a wide field of literature with a comprehensive bibliography. He explains personal solutions to issues raised in therapeutic encounters. The exercises throughout the text encourage readers to consider how they would respond to specific concerns in the therapeutic context. He considers the person-centred approach to be inherently holistic and believes it is reasonable to conclude that legal decisions directly affecting the emotional development of children and young people represents a legitimate area for the child-centred practitioner's practice. The book is not prescriptive: that individuals find a path or way of being that has meaning for them within a safe and effective therapeutic practice is central to person-centred values. The practitioner is a therapist who relies not upon tools and techniques with which to direct the patient, but who intuitively believes that offering appropriate conditions for emotional growth within the experience of the therapeutic relationship will enable patients to find a way that has meaning for them as individuals.

The author makes good use of visual images to clarify concepts, for example, the image of the iceberg that illustrates our consciousness (above the water's surface) and our subconscious state (below the waterline). The iceberg drawing is a metaphor describing the conscious and subconscious mind. These figures are only a glimpse of the intuitive personality of the author The first two chapters on developing practice provide a very honest account of the therapist developing skills, strengthened by short anecdotes of interactions with young people. There is a delightful lack of jargon, to say the book is "user friendly" is inadequate, it is a delight to read. This excellent text is an invaluable tool for students and therapists of counselling and psychotherapy, as well as people involved in supporting the development of young people. It is therefore highly recommended.

Conflicts of Interest

The author declares no conflict of interest.