The Management Aspect of Psychotherapy with Aggressive Children

Steven Frankel, MD
University of Michigan Medical Center

ABSTRACT: Psychotherapy with an aggressive child may require the imposition of rather firm limitations over aspects of the patient's aggressive behavior. The nature of this management strategy is determined by the individual child's psychopathology. The management aspects of the psychotherapy with two aggressive boys are illustrated in detail. In one case, stringent limitations were imposed when it was discovered that the boy's behavior was regressive and represented an effort to sadistically control people in his environment. In the other case, the behavior was initially left almost unchallenged; this boy's aggressive and delinquent behavior reflected an effort to achieve a sense of order in an inconsistent external and potentially chaotic internal environment.

Introduction

The concept "therapeutic alliance" in both child and adult psychotherapy refers to the overt and tacit agreement between patient and therapist to work together to understand the nature of the patient's difficulties [1-4]. As much as is possible, priority is given to verbalization and conceptualization as opposed to action. (Children of latency age and below are initially far less capable of achieving this ideal than are post-latency children and adults. In addition, within limits, a child's action is valued and used to provide associative information, which an adult patient provides verbally through free association. At best, a latency- or prelatency-age child develops a commitment to the therapeutic process only after a long and delicate initial phase of treatment [1].) Frequently, however, the unconscious attitude and related behavior that a patient brings to therapy oppose this process of exploring the patient's experience. Often, that behavior has the
purpose of inviting the therapist to act out a distorted or infantile relationship with the patient. Management in child psychotherapy refers to the activities and postures that are adopted by the therapist for the purpose of counteracting and preventing this counterproductive activity.

A management plan is derived from, and therefore conforms to, the (psychological) meaning of the patient’s behavior and takes into consideration his or her developmental needs and particular tolerances. It is evolved as the therapist gains an understanding of the patient’s behavior. Its form is unique to the patient for whom it is designed. Its description evolves and changes with the progress of the treatment.

The principle of management has clear parallels in adult psychotherapy. In work with adults, the efforts by a patient to act out in some form with the therapist, for example, by attacking him verbally or seducing him, are blocked and identified. Ultimately, an explanation for these behaviors is sought. These behaviors are considered resistances and more specifically are character or transference resistances.

A major difference between child and adult psychotherapy derives from the fact that children tend to engage in action instead of using words [5, 6]. It follows and is well accepted that in psychotherapy with children, it is frequently necessary to set limits on a child’s activity both because of the child’s developmental limitations and, at times, in order to contain the acting-out of a neurotic process [7]. (The reader is referred to the following references for a more thorough discussion of the issue of action and its management in child psychotherapy and psychoanalysis: a theoretical treatment of action and acting-out [7, pp. 26-53; 5, pp. 94-109; 6; 8]; the setting of limits in child psychotherapy and psychoanalysis [9, pp. 19-49; 7, pp. 26-53]; the concept of a parameter and the debate about the use of parameters in work with children [10-13].) The kind of limitations that are being referred to here include the limiting of such behavior as the destruction of material, the rendering of harm to the therapist, or the leaving and running away from the office.

With most neurotic and inhibited children, limitations over action can be communicated verbally or, at most, have to be enforced by removing something temporarily from the office or play room. The situation with aggressive children, however, is quite different. The usual means of enforcing limitations are often without effect [14]. It is the thesis of this paper that with certain aggressive children, firm controls often involving the physical handling of the child or the strict imposi-