Chapter 2
Approaches to therapeutic play

COMMUNICATION THROUGH PLAY—A 'THIRD THING'

Many people working with children can recall a time when they have sat with a child on a chair opposite them and they have attempted to find out how the child was feeling. The adult, as uncomfortable as the child, resorts to questions. 'How are you getting on at school?' 'All right' 'What's your favourite subject?' 'Games.' 'How do you feel about your dad being away?' 'Don't know.' 'How are things at home?' 'All right,' 'How do you get on with mum and Paul?' 'All right.' Communication has not even started. Clare Winnicott explains how to bridge the communication gap, She writes:

> We spend a good deal of time creating the conditions which make communication possible. We try to establish between ourselves and the children a neutral area in which communication is indirect. In other words we participate in shared experiences, about which both we and the children feel something *about something else,* a third thing, which unites us, but which at the same time keeps us safely apart because it does not involve direct exchange between us.
>
> (C.Winnicott, in Tod 1968:70)

The 'third thing' may be an outing or journey, a pet, a hobby or interest, but equally it may be a toy or game, or simply play. An informal shared play experience is not threatening and takes out the strain of communication, enabling the worker to build a relationship with a child which is 'personal but yet structured' (Winnicott, in Tod 1968:57).

The ultimate aim of communication is to help children to sort out the muddle in their lives 'so that things add up and make some sort of sense', preventing and relieving some of their distress. It is concerned with linking real events and people in children's lives with their feelings about them. Clare Winnicott writes:

> We have to be able to reach them and respond to them at any given moment and be willing to follow them as best we can. Of course we shall not always understand what is going on or what they are trying to convey to us, and often this does not matter. What matters most is that we respond in a way which conveys our *willingness to try to understand*. And it must be obvious that we really are trying all the time. This

> in itself can provide a therapeutic experience. Having reached the child we try to look at his world with him, and to help him sort out his feelings about it, to face the painful things and discover the good things. Then we try to consolidate the positive things in the child and in his world, and to help him make the most of his life.
>
> (C.Winnicott 1964:46 and 57)

This chapter explores the different ways in which workers use play 'to try to understand' and to help children to face the painful things in their lives, to find the strength to grow and develop, and to make the most of their future. It starts with Axline's non-directive play therapy and goes on to examine the use of play in child psychotherapy, looking at diverse ways in which these approaches may be applied by other workers. It considers the range of focused or structured play techniques and their application. It examines developmental and behavioural play techniques. Finally it considers play methods in group work with children and in the growing area of family work.

NON-DIRECTIVE PLAY THERAPY

Perhaps most people who become interested in play therapy were initially inspired by reading Virginia Axline's (1964a) *Dibs—In Search of Self,* a moving account of how she enabled a disturbed and withdrawn boy to heal himself and to reveal his incredible intellectual gifts. She further describes her approach in *Play Therapy* (1947, republished in 1989). Hernon-directive approach is based on the belief that children contain within themselves both the ability to solve their own problems and the 'growth impulse that makes mature behaviour more satisfying than immature behaviour'. She writes:

> The therapeutic value of this kind of psychotherapy is based upon the child experiencing himself as a capable, responsible person in a relationship that tries to communicate to him two basic truths: that no one ever really knows as much about any human being's inner world as does the individual himself; and that responsible freedom grows and develops from inside the person.
>
> (Axline 1964a: 57–8)

Axline equipped her playroom with a wide variety of play materials, including sand, water, paint and drawing materials, finger paint, a dolls' house and family, miniature cars and people, a nursing bottle and perhaps an inflatable rubber figure. Within this protected setting the child was free to choose what to do. The child's relationship with the therapist was crucial. Axline, who worked in the United States, was influenced by the philosophical approach of Carl Rogers's (1951) active non-directive counselling. She used the technique of reflective listening, based on the counselling principles of empathy, warmth, acceptance and genuineness, (described in Truax and Carkhuff 1967). Play therapy adds to this counselling method by using the child's play as a means of communication to the therapist (Dorfman, in Rogers 1951). The therapist's task is to recognize the feelings which the child is expressing in speech and play and to reflect these back so that the child can get some insight into its behaviour. There is no attempt to direct play or to hurry the child. The only

limits are those necessary to keep the therapy anchored to the real world and to make children aware of their responsibilities to the therapy.

Axline (1947 and 1989) sets out eight principles for non-directive play therapy.

1 'The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible.'

   She explains to a new child that it may play with any of the things in the playroom or use them in any way it wishes. She does not suggest anything particular that the child might do. If the child sits in silence, the therapist accepts it and sits quietly too.

2 'The therapist accepts the child exactly as he is.'

   The therapist must be neutral. Praise and encouragement are as inappropriate as criticism and disapproval, since both imply judgment. If the child does a beautiful painting she will not praise it because it is the child's opinion that matters, not hers.

3 'The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely.'

   The child needs to feel free—for instance, to 'beat up the mother doll or bury the baby in the sand, or lie down on the floor and drink from a nursing bottle… without shame or guilt' (Axline, in Haworth 1964:264). Axline illustrates her approach. She went into the playroom with Oscar who had reluctantly left his mother. He screamed 'Don't shut the door'. She replied: 'You don't want me to shut the door. You're afraid to stay with me if we shut the door. Very well we'll leave the door open and you can close it when you feel like it' (Axline, in Haworth: 98–9).

4 'The therapist is alert to recognize the feelings the child is expressing and reflects those feelings back to him in such a manner that he gains insight into his behaviour'

   For example, Oscar looked round the room and said 'I'll bust up everything in here!' Axline responded, 'You're feeling tough now'. She warns against falling in to the trap of responding to the *contents* of his words by saying 'You can play with the toys any way you want to but you can't bust them up'.

5 'The therapist maintains a deep respect for the child's ability to solve his own problems if given an opportunity to do so. The responsibility to make choices and to institute changes is the child's.'

6 'The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way; the therapist follows.'

   If the child needs or asks for help in play, she gives only the limited amount needed at the time.

7 'The therapist does not attempt to hurry the therapy along. It is a gradual process and recognized as such by the therapist.'

   Axline illustrates this in her description of a six-year-old's play with a doll family and sand tray.

> He took the boy doll out of the house and said to the therapist: 'She is sending the boy out where the quicksand is… He cries and tells his mother that he is afraid but she makes him go anyway. And see. He is sinking down and down and down into the quicksand.' The boy, showing much fear and anxiety, buries the doll in the sand.

> This child is certainly dramatizing his fear and his feeling of insecurity and lack of understanding… If she follows the child she will say: 'The boy is being sent out of the house and he is afraid… He tells his mother he is afraid, but she makes him go out anyway and he gets buried in the sand.' If she had said, 'You are afraid and your mother doesn't pay any attention to your fears and that scares you still more', she is getting ahead of the child and interpreting… Perhaps the interpretation is correct, but there is a danger of thrusting something at the child before he is ready for it.
>
> (Axline (1964b), in Haworth: 262–3).

8 'The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship.'

The notion of the child assuming responsibilty for itself is crucial in Axline's approach. It underlies her expectation of the child taking the initiative and choosing how to use time in the playroom. As in all play, freedom is possible only because of the safe limits of the situation. The boundaries consist of time, one hour, usually weekly, and space, the playroom and materials within it. The child is not permitted to hurt itself or the therapist and some limits may be placed on the destruction of materials. These limits are not laid down at the outset but explained to the child as the need arises. The child is helped to understand that the playroom hour is only part of its life and that the real world imposes other constraints and limits to which it must adapt, whatever it feels. For example, Axline told Dibs he had only three minutes more before it was time to go home.

> Dibs suddenly stood up. 'No!' he shouted. 'Dibs no go out of here. Dibs no go home. Not never!'
>
> 'I know you don't want to go, Dibs. But you and I only have one hour every week to spend together here in the playroom. And when that hour is over, no matter how you feel about it, no matter how I feel about it, no matter how anybody feels about it, it is over for that day and we both leave the playroom'.
>
> 'Cannot paint another picture?' Dibs asked me, tears streaming down his face.
>
> 'Not today', I told him.
>
> He sat down muttering 'No go home. No want to go home. *No feel* like going home.'
>
> 'I know how you *feel*', I told him.
>
> (Axline 1964a: 448–9)

Non-directive play therapy based on Axline's principles can be effective in reaching feelings of which the child is unaware and bringing them into consciousness where they can be dealt with. However, as the example of doll play in the sand shows, the therapist does not make direct interpretations of play but stays within the symbolism expressed in play, until the child is ready to move on. Since therapy goes at the child's pace and direction it is unlikely to damage further a child by uncovering unmanageable feelings which neither child nor perhaps the therapist are ready to handle. The adult, however, needs to be alert to areas

the child is avoiding, This method is invaluable in diagnosis when the worker has limited information as to how the child is feeling and what is the problem for the child. Non-directive play therapy is particularly suitable for use by workers who do not have a psychodynamic training. Its drawback is that it can be a very slow process and there may be few workers who have time to offer it. It offers, however, great hope of recovery to some deeply disturbed children.

Children's Hours

The Children's Hours Trust, founded by Rachel Pinney, a medical doctor who had earlier worked with Margaret Lowenfeld, offers 'Children's Hours' in south-east England. These use non-directive principles similar to Axline's, including reflective listening techniques which Pinney has simplified so that very inexperienced workers may safely employ them. She uses (1983) and teaches 're-capping', in which the adult describes aloud the child's actions in play, a sort of running commentary. She believes that 'children, whatever their circumstances, benefit from having a time and space in which to play out their thought and feelings with an attentive adult who receives all that is said and done without passing judgment' (Pinney 1990:4).

A Children's Hour takes place in a playroom containing robust unstructured material which feeds the imagination, 'such as sand, water, clay and paint; music or soundmaking equipment; giant-sized cardboard boxes; sagbags, blankets and mattress; bricks of all shapes and sizes and other building equipment; soft-balls, small models of people and animals, puppets, kitchen equipment, pipecleaners, hammer toys and all kinds of miscellaneous objects' (Pinney 1990:5). The child is also allowed to go out. The adult takes responsibility for limits. Each Children's Hour begins with an introduction, for a five-year-old along the lines of:

> Hello James. You've come here for a special playtime. You can do anything you like, and we can go outside if you want to. I'll make sure nothing is dangerous and nothing gets damaged… We've got till the big hand says four o'clock. And I'll be with you.
> (Pinney 1990:6)

The adult makes itself totally available to the child, and makes the child aware of this by 're-capping' the child's activity, or lack of it—for example, 'You're looking around—looking in the box—you've found a lion'. Closer to Axline, feelings as well as actions are re-capped—for example,' You're kicking that chair over—you're really angry', or 'You're crying—you're really hurting'. The adult may mirror the child's body language. With one child who sat still for 50 minutes the adult copied his body movements and facial expressions; much later he recalled this session as helpful Very occasionally contact is made with a reluctant child by the taker starting to play itself (hostessing); the taker ceases to take the initiative as soon as the child joins in. If the child puts the taker into a role, such as prisoner or monster, the taker takes that role but is ready to drop it as the child indicates. At all times the adult avoids making suggestions, interpretations or assessments. A session ends

with a ritual form of words, 'It's nearly the end of your special time, and I'm going to count you down slowly from ten to one… And now it's the end of your special time for today' (Pinney 1990:8). These mark the child's re-entry into the world outside. Jenny Senior's account (see Chapter 5) of Children's Hours with Keith illustrates this approach, also used by Anna Sanders in work with both children and adults (see Chapter 4).

PSYCHOANALYTIC PLAY THERAPY

Play therapy has been taking place in Britain for over 50 years. Students of Freudian psychoanalysis, such as Anna Freud, Melanie Klein, Donald Winnicott and Margaret Lowenfeld, each in their own very different ways, have developed the theory and practice of psychoanalytic work with children.

Anna Freud's child psychoanalysis

Anna Freud worked with her father Sigmund Freud in Vienna and moved with him to London where she founded the Hampstead War Nurseries, later to become the Anna Freud Centre for the Psychoanalytic Study and Treatment of Children. Before starting therapy she aimed to create a loving and caring relationship with the child so that the child would like her and feel dependent on her. Play was one of the main ways of achieving this. Also by observing play she was better able to understand the child's problem. Unlike Melanie Klein who thought that all play was symbolic, Anna Freud believed that it could be a re-playing of real events or even pure exploration. For instance, a child who looks *in* her therapist's handbag is not necessarily looking to see if her mother's womb is holding another baby. After initial assessment she used play methods less than 'free association', asking children to 'see pictures', tell stories, draw, or describe their dreams.

Anna Freud saw playing in therapy as a means of permitting children to talk about conscious feelings and thoughts and to act out unconscious conflicts and phantasies. Interpretation to the child of the symbolism of its play might follow, but only if it was suggested by a good deal of material. The positive tie created earlier helped the child 'face up to the often very painful revelation of repressed material' (A. Freud 1965). The immature self of the child used the analyst as a model for identification. Anna Freud's analytic work was often with latency age children, those who had developed strong psychological defences and therefore resistances to therapy. She always kept sight of the child's real world and worked only slowly down from reality and conscious feelings towards deeper levels of the child's unconscious. She did not think a quick, deep interpretation could be lastingly therapeutic.

Melanie Klein's psychoanalytic play therapy

Melanie Klein started her psychoanalytic work in Berlin and, like Anna Freud, moved to London as the Second World War loomed. In sharp contrast to Anna Freud, Melanie Klein made profound interpretations to children of the unconscious meanings of their play from the outset. If the child strongly rejected her interpretation she felt that this indicated that

it was correct. When a child accepted an interpretation its anxiety and guilt would lessen, enabling the symbolic exploration of feelings, free of the fear of damaging real people. Her interpretations often involved sexual meanings which she did not hesitate 10 offer to the child. It is perhaps this which led many people to reject her ideas, although with the current concern about sexual abuse a re-appraisal may well be due.

Klein's most significant contributions have been her explanation of the origin of the child's emotions, tracing them back to infancy, (as Chapter 1 has described), and her specific use of play in therapy, She believed that children's play could be used as the equivalent of free association in adult psychoanalysis, revealing unconscious anxieties and phantasies. She concluded that it was possible to work with very young children. Many of her patients were under five years old and some were as young as two. Klein thought it was important to analyse the child's transference—that is, the child's feelings towards the therapist which had their origin in the earlier mother-child experiences, Anna Freud, in contrast, felt that transference was less significant since children were still developing their relation-ship to their parents; parents were still real and present as love objects, which also meant work with the parents could directly benefit the child.

Klein was probably the first therapist to use a carefully planned playroom Her materials included a large number and variety of miniature toys with many human figures, drawing and painting materials, materials for cutting out, and water. Each child's materials were kept in its own special drawer. Children directed their own play. If they gave the therapist a part in role play she would play the part allotted. They might play shops, doctor and patient, schools, or mother and child. Klein comments,

> In such games the child frequently takes the part of the adult, thereby not only expressing his wish to reverse the roles but also demonstrating how he feels that his parents or other people in authority behave towards him—or *should* behave.
>
> Sometimes he gives vent to his aggressiveness and resentment by being, in the role of parent, sadistic towards the child, represented by the analyst.
>
> (Klein, in Mitchell 1986:41)

The therapist neither encourages nor disapproves of expressions of aggression but interprets their meaning to the child.

Klein set the model for much subsequent child psychotherapy and play therapy. More recent work in this field, such as Hoxter (in Boston and Daws 1977), and Boston and Szur (1983), as well as Copley and Forryan (1987), draws on her explanation of the mental development of babies, and on developments of these ideas in theories of 'holding' and 'containment'. Like the 'good enough' mother the therapist provides containment of the child, providing a mental space in which she attends to and reflects on the child's communication, This communication may be received through the symbolism of the child's play. For example, Copley and Forryan describe Edward's game of a cops and robbers chase in which he showed anxiety about the outcome. When he changed the robber's van into a refuse collection lorry they suggest he 'may have portrayed an underlying hope that the worker would be able to collect together and hold some of his conflict' (Copley and Forryan 1987:231). The child's communication may also be received through becoming aware of

the transference—that is, the feelings which the child arouses in the therapist, which may be the child's own feelings projected on to the therapist. For example, play therapist Jo Carroll started to feel irritated and angry when a child kept barking like a dog, until she realised that this anger was the child's own feeling about a parent, projected on to the therapist. Interpretation of play continues to form a major part of current therapy, although a more cautious approach is adopted in which the timing of the interpretation becomes important.

An understanding of the workings of the mechanisms of projection and introjection and the use of containment, and the recognition and use of the transference, are invaluable methods which can be learned and applied by workers who are not trained in child psychotherapy. The use of direct interpretation to the child needs to be used much more cautiously and only with skilled supervision.

Donald Winnicott and Erik Erikson—play as therapy

Donald Winnicott has not only provided a theory of play but has also informed the practice of play therapy. He observed that the pre-occupation of a child playing is akin to adult concentration. In play, children use objects from the real world in service of some aspect of their inner world, and this precarious interplay makes play an exciting and even potentially frightening creative experience (see Chapter 1). Since play is a 'being honest with oneself' then 'playing is itself a therapy' (D.Winnicott 1971:50). Erik Erikson, a child psychoanalyst who started as a teacher in Anna Freud's school in Vienna before going to the United States, also thought that children heal themselves through play.

> Modern play therapy is based on the observation that a child made insecure by a secret hate or fear of the natural protectors of his play in family and neighbourhood seems able to use the protective sanction of an understanding adult to regain some play peace. Grandmothers and favourite aunts may have played that role in the past; its professional elaboration of today is the play therapist. The most obvious condition is that the child has the toys and adult for himself, and that sibling rivalry, parental nagging, or any kind of sudden interruption does not disturb the unfolding of his play intentions.
>
> (Erikson 1965:215)

Although Winnicott used interpretation, illustrated in case studies in *Playing and Reality* (1971) and *The Piggle* (1980), he believed that fundamental psychotherapy could take place without it. *'The significant moment is that when the child surprises himself or herself.* It is not the moment of my clever interpretation that is significant' (D.Winnicott 1971:51). In this he differed sharply from Melanie Klein, observing that she was only interested in the content of play as a way of receiving communication from the child and that she had not recognized the value of the child 'playing'. Winnicott makes 'a plea to every therapist to allow for the patient's capacity to play, that is, to be creative in the analytic work. The patient's creativity can be only too easily stolen by a therapist who knows too much' and does not hide his knowing (D.Winnicott 1971:57). This was as true for adults, he felt, as for children.

Erikson recognized that an excess of emotion, excitement or anxiety could disrupt play. It could happen suddenly or it could slowly inhibit play. The process is similar to 'resistance' to transference in adult therapy. It occurs when painful repressed material is getting too near the surface. The therapist's task is to try to understand the meaning of the play which led up to disruption. The therapist may interpret this to the child, trying to put its experience into words to increase its insight. Erikson used quite deep interpretations—for example, a child who built a rectangle of inward-facing dominoes was helped by the interpretation that it was his coffin. However, the level and timing of interpretation was crucial. Winnicott saw that playing might reach its own saturation point at which the child could not contain any more experience.

Erikson recognized that play therapy does not take place in a vacuum but that social context is crucial. A child's identity ultimately depends on finding a reflection within the child's own culture. Play therapy could only be successful where there were social and cultural reinforcements, both in the family and beyond. This could be denied, for example, to a black child in a white culture.

Margaret Lowenfeld's Make-a-World technique

At her Institute of Child Psychology in London, now defunct, Margaret Lowenfeld (1979) encouraged children to construct a series of miniature worlds in a sand tray, choosing from the enormous collection of miniature world material, stored in tiny drawers. Items included figures of people, soldiers, wild, domestic and farm animals, houses, cars, boats, fences and trees. She would tell children to use pictures in their heads to construct their world. When completed she asked the child to explain it to her. She thought that the therapist's role was to encourage and help, and that this was more useful than making interpretations, which she used only sparingly. Her own understanding of the child's play, however, still largely used sexual symbolism. Lowenfeld noted some recurring themes in children's worlds, such as a dam holding back water (feelings) to be eventually released. A child often built a volcano, representing internal turmoil, at the point where it had stopped getting rid of its bad feelings by projection.

The make-a-world technique has been borrowed and adapted for wider use. Sally Maxwell provided a sand tray with miniature toys, in a separate small room, in a Camden Family Centre. Children were offered regular opportunities to play there on their own with an attentive adult. The role of the adult was reflective listening, re-capping what the child was doing as it played (Pinney 1990). Elizabeth Newson, at Nottingham's Child Development Research Unit, recommends the technique for use in helping a wide variety of children, including children in care, slow learners and terminally ill children. She feels that it enables children to communicate with themselves and to look at their own predicaments which those involved with them may not be wholly aware of or tend to 'pat down'. Modifying the technique for non-psychoanalysts she warns against making any value judgments, such as saying 'This is a nice world', and suggests simply asking the child 'Whether he wants to tell you about the world. The first two times the child makes a world it is left at that. The third time he is asked if he is in his world' (Newson 1983:17). Children may use a symbol, such as a monkey or an elephant, to represent themselves. No

interpretation is offered. Newson suggests following a make-aworld session with drama play (described later).

ART THERAPY

Art therapy recognizes the creativity of children's play. It focuses on the creative processes of drawing, painting and three-dimensional work. Children may be exploring and playing with art materials as well as using them to create an image. Art therapist Susan Tumer finds that painting and play offer the child

> A way to objectify and express thoughts and feelings, to experiment with relationships, to find new approaches, or to absorb and grow through past experiences by making a symbolic form in which the experiences can be safely contained and re-experienced and in time healed. Furthermore, strong statements can be made in an acceptable form, for example, aggressive, non-acceptable behaviour can be expressed in a painting where it can be worked through. The need to act out is reduced and this may bring about a positive change in the child's development and behaviour. It is also true to say that if the child needs to be destructive in his painting he also has the opportunity to take action and to restore in the art work what he needed to destroy for a time. This can be very helpful in enabling the child to overcome his fears of being overwhelmed by negative emotion.
>
> (Turner 1988)

The role of the therapist follows Axline's non-directive principles, including those on limits. Susan Tumer aims to provide a relaxed and safe setting, which as far as possible is always physically the same, in which the child feels 'contained'. Like many peripatetic workers she may not have the use of a room specifically designed for her work. She sets out art materials for the child at the edge of a large plastic sheet on the floor and sits herself on a low chair close by. She continues:

> The art therapist is trained to be alert and sensitive in recognizing the emotional nature of the painting/play processes. In the session her intervention and active involvement will vary depending on the needs and circumstances of the child. It may be enough that the child feels safe to reveal powerful feelings symbolically and works through them internally at an unconscious or conscious level without the therapist's intervention or discussion. The therapist maintains a respect for the child's ability to solve his own problems. In painting, the child takes the responsibility to make choices and to institute change. However, sometimes in therapy the child may need more active acknowledgment and interaction with the therapist concerning the communication within the painting/play. It may then be appropriate for the therapist to name and to reflect the feelings/anxieties back to the child so that he is not overwhelmed but will gain insight and, with the support of the therapist, be able to overcome his particular difficulties.
>
> (Tumer 1988)

This approach is exemplified in art therapist Ann Gillespie's account of work with Sonia, an 11-year-old black child trying to cope with life in a foster family after a childhood of uncertainty and violence. From a beginning of inertia and hopelessness, with Sonia's only burst of energy going into drawing a sad little black dog (herself?), her relationship with the therapist grew as 'Sonia drew and talked about countless cradles, babies and mothers', including babies who looked 'too old' (herself again). Much of their communication was unspoken, operating through the medium of drawing, painting and modelling, 'entrusted as I am with elements of her that are so deep and hurtful that they have to be hidden in fairy tale pictures and thick crude paint'. Gillespie continues:

> After she discovered I had conferred with her family, she drew a fortified castle, warning me to keep our special relationship defended from outsiders. Twin-towered it stands, surrounded by its moat, door securely barred, alone in a large hilly countryside. Outside stand two riderless horses, one brown, one white (like us), saddled and waiting until we are able to continue our journey.
>
> (Jefferies and Gillespie 1981:14)

Art therapy helped Sonia to cope with deep levels of emotional pain, freeing her to benefit from relationships offered by her foster parents and her social worker.

Art therapy is perhaps closest to Winnicott's approach to play therapy, in that the child's self-healing through art or play is as important as the 'containment' offered by the worker. It can be helpful to children, and adults, of all ages, and is often acceptable to older children who feel too grown-up to play but may not be able to cope with talking therapies, It is used in work with children in a variety of contexts, including under-fives family centres, child psychiatry, black children, children in hospitals, assessment centres, residential special schools, described in Case and Dalley (1990), and family placement (Gillespie 1986). A more general introduction to art therapy is Dalley (1985). While it is a specialized field and art therapists expect to nurture and be fed by their own creative art process its basic approach can be used by others.

For example, social worker Chris Braithwaite (1986) notes what aspects of a child's drawing take most effort and concentration, what is missing as well as what is there, and how each person is placed relative to others. She may comment quietly 'Two houses' (pause) 'I wonder who lives there?' but remains tentative and does not probe beyond the child's painful avoidance of issues. She describes how 15-year-old Mark, about to return home from care, drew a picture of pointing fingers, illustrating his feeling that dad had always called him a thief and his fear that his step-mum did not want him, and an exploding bottle. He admitted that he had been close to smashing a window but instead was able to talk 'about his anger at being caught "in the middle" in his family and between his social worker and the resident staff' (Braithwaite 1986:17). The worker did not need to speak. The therapy of drawing had enabled the child to put his feelings into words where they could be thought about. Chris Braithwaite sums up the adult's role.

> When working with a child's drawing, the intention is not to interpret and hence impose an 'adult' or 'professional meaning on it, but rather to explore it alongside the child, while he makes sense of it and himself to himself… The art is to be non-directive but to 'actively listen', confident that the process in itself is sufficiently therapeutic to redress imbalances and provide the impetus for progress…Drawings can simuitaneously supply the means of communicating and alleviating a client's 'dis-ease'.
>
> (Braithwaite 1986:16–17)

FOCUSED PLAY TECHNIQUES

Early forms of focused play techniques, such as release therapy, concentrated on specific anxieties. Relevant play materials were offered at frequent intervals so that the children could overcome their fears by repeatedly playing out the situation provoking them. For example, a child afraid of using the potty would be offered dolls and potties to play with. Today the use of focused play is more varied. Where the worker has some knowledge of what has happened in a child's life the child may be provided with specific play materials, such as doll families, which enable the child to re-enact events or to indicate what it would like to happen. Jewett (1984) suggests an open-mouthed dinosaur, a van with sliding doors that can take people and furniture, a hulk-like figure and a police car, to help children to play out angry feelings and re-play their experience of loss and separation. Alternatively the worker may be more active in directing play, either openly or more subtly. The worker may introduce play themes through participation in pretend play, or may ask children to talk to the figures or puppets they are playing with or drawing and ask them to speak as the figure, or write letters to them. Such Gestalt methods are described by Oaklander (1978) and their use is spreading—for example, in Madge Bray's (1991) work. The theory behind them is that it is more useful to help children to deal with their present feelings than to go back to early traumatic experiences.

Oaklander suggests many fantasy and projective techniques. For example, children might be asked to draw their family as symbols or animals, to go on a fantasy journey, perhaps in a guided fantasy, and draw their room or the place they get to, to create their own world, or a particular feeling, on paper, just using shapes, lines, curves and colours, or to draw themselves as a rosebush or a boat in a storm. Older children might be asked to choose a toy in the room and then to imagine that they are it, describing how they are used, what they do and what they look like, and what they want to do. The worker might set up a structured situation such as a family scene in a dolls' house, and the child told, for example, that they are all arguing and asked what happens next. In another projective technique a child might be asked to draw a house (symbolizing the mother), a person (the father) and a tree (the child) (Sluckin 1989). Donald Winnicott used his famous 'squiggle' technique as a way of quickly establishing communication between child and adult on

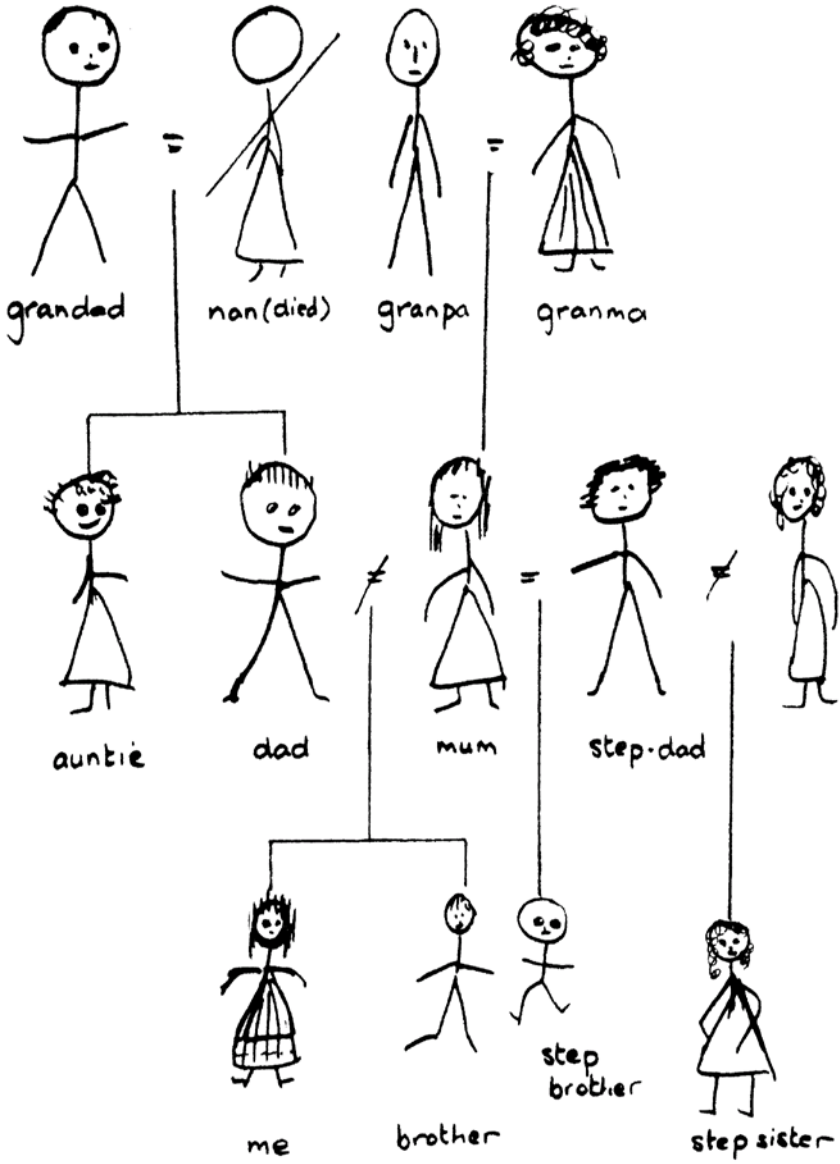

Figure 2.1 **Family tree or genogram**

the level of unconscious processes. He would draw a random squiggle and ask the child to turn it into something, then in turn ask the child to draw a squiggle which he would then complete.

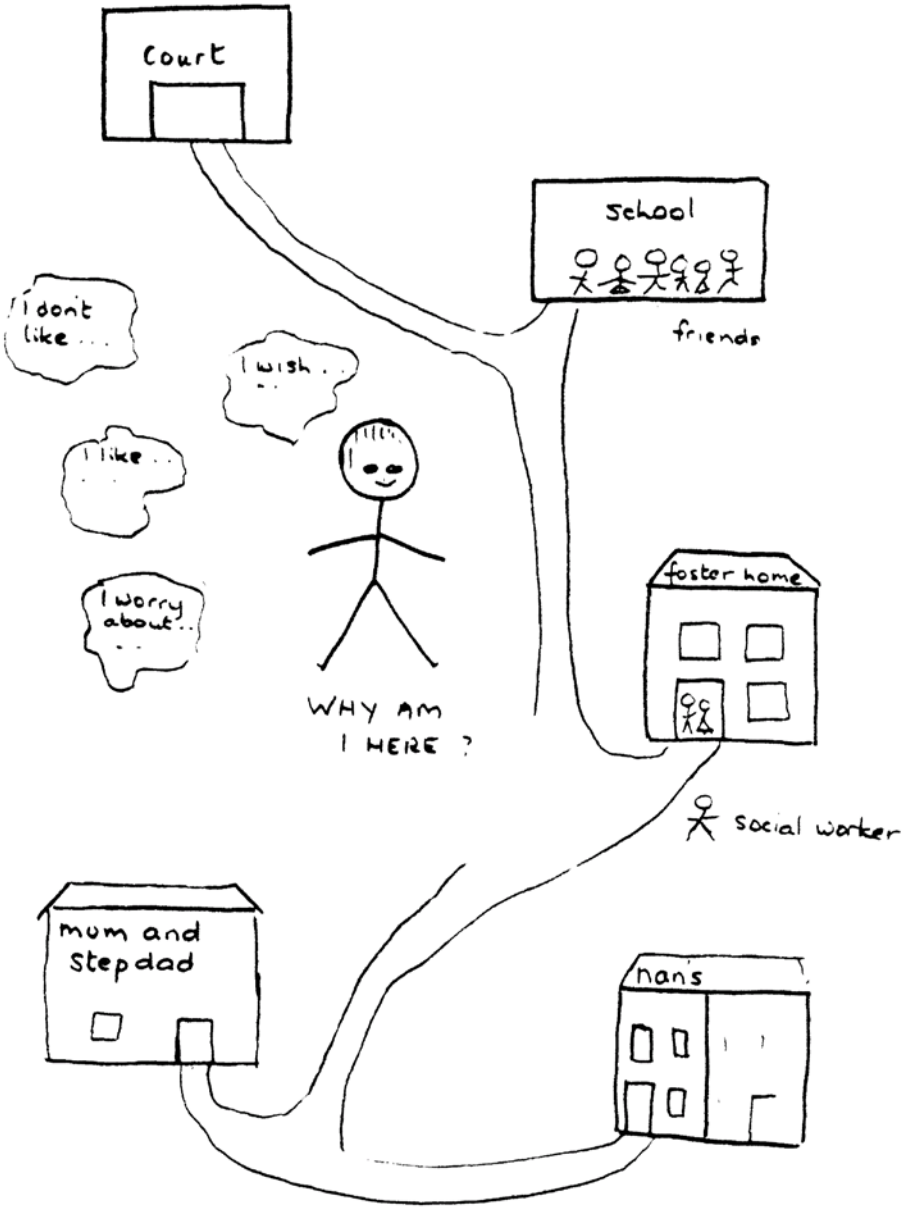

Figure 2.2 **Ecomap**

The use of a 'third thing' is a strategy used by many social workers, especially those involved in long-term work with children in care, Many play techniques are now used to enable worker and child to get to know one another, to help uncover a child's feelings and

to permit their expression. Ecomaps, picture genograms or illustrated family trees, picture flow charts and time drawings are widely used (Figures 2.1–2.3). Card and board

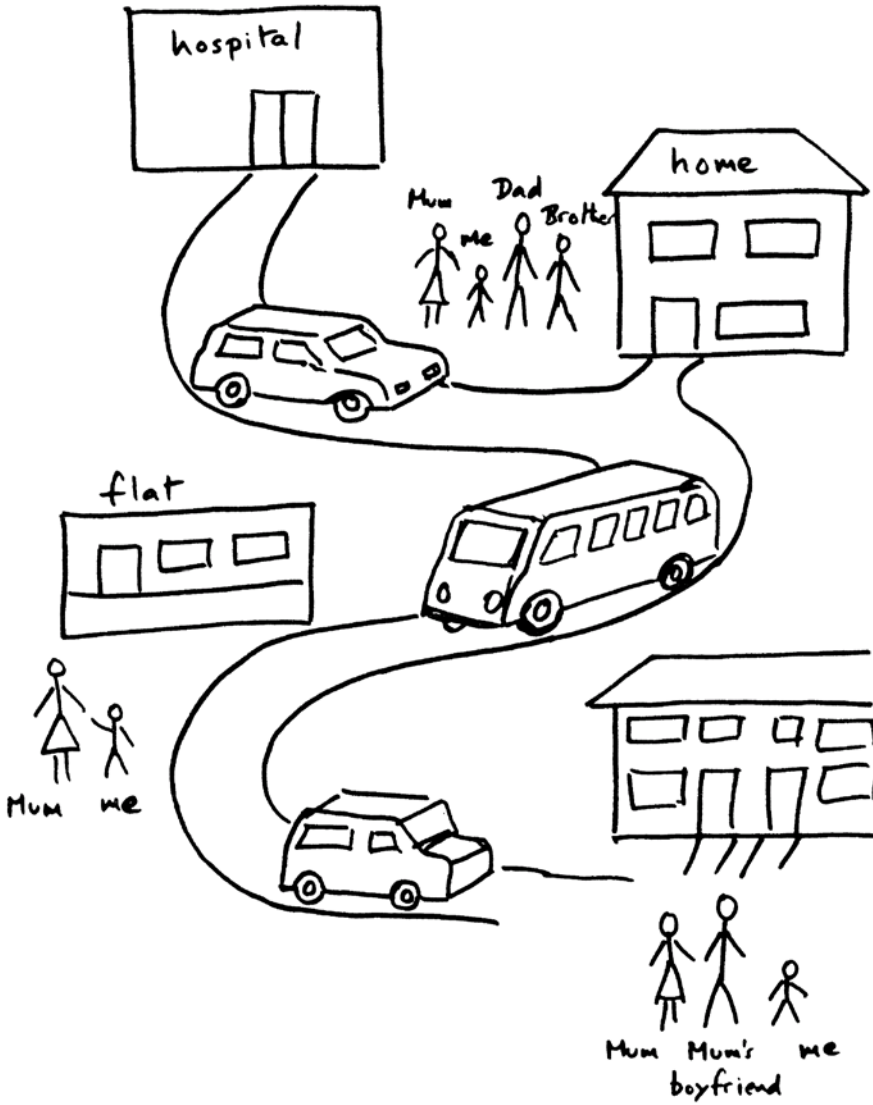

Figure 2.3 **Picture flow chart (1)**

games, often invented by the worker to meet a particular need, are popular. A child may be encouraged to draw or paint its family or some aspect of its life. Cathartic techniques, including water techniques, candle ceremonies for grief work, and planned anger work are used by workers prepared to handle strong feelings (Jewett 1984, Owen and Curtis 1988,

Redgrave 1987). Life-story books are familiar to most social workers, but there are also numerous games with rules, playful tasks and play situations which have been devised to help children to make sense of their past, present and future, Many of these approaches concentrate on children's difficulties in the real world and are less concerned with their inner conflicts, although they help children to distinguish between reality and phantasy. They deal with conscious or near-conscious feelings rather than deeply unconscious ones. These focused play techniques will be discussed further in later chapters.

Some focused approaches border on non-directive play. In one form of drama play the worker tells the child 'Anything that happens now will be because you want it to happen. I will play with you as much as you want, but you must tell me what to do' (Newson 1983: 17). The worker sits on the floor and waits to be asked to join the game. Toy telephones are provided to ease communication. If the worker is not invited after ten minutes the worker may pick up a telephone and ask the child to 'come to tea' or 'come to the shop'. Otherwise the child is free to direct play and people within safe limits. Newson 's aim is to offer the child total attention and an experience of being in control, as well as relevant new experiences and the opportunity to symbolize and communicate feelings and problems through play.

Responding to the child's communication

When using focused play techniques the worker's role is to respond to the child's communication but not to make hasty interpretations of play. Clare Winnicott warns against going ahead of children and verbalizing or interpreting feelings before children have shown that they are ready to think about them. She reassures us that children work things out in their own way. The adult's role is to wait alongside the child, especially with suspicious, withdrawn, depressed or even extrovert children. With angry and hostile children, whether anger is expressed overtly or by passive indifference, adults must meet and survive their hostility, even when feeling out of their depth and not understanding. Later the worker can help them to put their feelings into words. A brief acknowledgment of a painful or frightening experience may touch deeply and there is no need to 'wallow' in feelings.

Workers' responses vary according to their training and background. Some deal solely with the child's conscious feelings and views expressed through play, Others recognize less conscious feelings in the child's symbolic play and may choose to convey this recognition to the child, usually working within the symbolism, saying, for example, 'This boy doll looks as if he's very cross with the big brother doll', avoiding the direct interpretation of 'Perhaps you are feeling very angry with your big brother'. Such an approach can be effective, especially with younger children. Going at the child's pace makes the therapy more bearable to the child at any age.

In Violet Oaklander's approach, while the worker does not interpret the child's play the child may be asked to do so, and in this way is helped to own its own feelings and projections, The worker may, if it feels right, direct the child's awareness to the content or the process of play, saying, for example,' You like to do that slowly', 'You are burying the tiger', 'This plane is all alone', oreven 'You sound angry'. If a pattern repeats itself, the child might be asked about its life, 'Do you like things tidy at home?'. This may be asked during play or

afterwards, Children may be asked to repeat a situation yet again or exaggerate an action, such as a fire engine doing lots of rescuing, and asked 'Does that remind you of anything in your life?'. The child with the fire engine replied that since his dad had been away his mother expected him to do everything! Children are often asked to speak as the people, animals or objects in their fantasy or drawing—for example, 'You be that fire engine. What does it say?', 'What might that snake say about itself?', 'What would the fire engine say to the truck if it could talk?', or 'Do you ever feel like that monkey?' (Oaklander 1978:162). Where they are ready for it children are helped to go beyond symbolization to conceptualization of their feelings, becoming able to reflect on them, developing a stronger self-awareness and self-esteem, and helping them to reach integration.

Sensory and regressive play

Some focused methods work at profoundly unconscious levels. Chief among these are sensory and regressive play. These can help children who have suffered severe deprivation and loss, as well as children in hospital and children with learning difficulties. Sensory work with emotionally damaged children is based on the belief that a child's senses are dulled by the many traumas that have been suffered. Children have often either withdrawn and isolated themselves from contact with their environment, or else, particularly in the case of abused children, submerged their self to accommodate adult expectations (Thom 1984). They

> have blocked off the feeling part of them and hence do not have the means to know what they feel or the tools to express these feelings. Development of the senses -of the 'contact function'—looking, talking, touching, listening, moving, smelling and tasting has therefore become an important part of work with children and a significant part of the development of the sense of self.
>
> (Simmonds, in Aldgate and Simmonds 1988:14)

Children can re-learn to become aware of their bodies and their contact with the world around them. Violet Oaklander (1978) has been the source of inspiration for much recent sensory work, especially by social workers for children in care.

Kate Burke, a family placement worker with the Catholic Children's Society, often uses sensory work as part of a programme of intensive work in preparing children for new families (see Chapter 9). She aims 'to renew and strengthen the basic senses that an infant discovers and flourishes in', within a relationship which gives the child individual time and attention and builds trust. Sensory work gets in touch with and validates a child's feelings on two levels, the external and the internal. She gives the example of the girl who cannot tell hot from cold; on a hot day she sweats in heavy clothing and does not think of taking any off. Her senses are blunted, a sign of her low self-esteem. Sensory work can 'unfreeze' her, putting her in touch with her senses so that she can use them again. Work might start by asking about the kinds of textures she likes and dislikes feeling. She expands a child's vocabulary of 'feeling' words, which helps in later life work and abuse work. Each week she concentrates on one of the senses—touch, sight, sound, smell and taste . Every session begins with relaxation and breathing exercises, and an explanation of what will happen in

the session. Sessions end with a summary of what they have done and checking out the child's understanding of this, praising the child for any particular cooperation or ability. Day-to-day opportunities for sensory experiences are seized, and foster parents or carers are asked to follow up each session in an enjoyable way with similar experiences. Her programme includes the following ideas:

Touch—Relaxation and breathing exercises, paying attention to different sensations. Explain what we will be doing. Begin by exploring our own bodies, touching ears, toes, hair. What can we feel? How do we feel? Touch a collection of objects made of wood, rubber, rock, sponge, fur, silk, tissue, cotton wool and face cream, talking about how they feel and using words such as bumpy, fluffy, sticky, warm, prickly, spongy, hairy, freezing, tingly.

Use clay, sand and water trays, taking time, and touching with hands, feet or noses. Use finger paints and talk about touching and feeling. From a bag of hidden objects, ask the child to find things that feel soft, hard, silky, etc. End the session by discussing what we have done. Ask carers to continue exploring touch during the week, in the house and outside, with grass, trees and earth.

Sight—Begin by looking around the room, then look at each other, and then look in the mirror, describing what we can see. Choose an object in the room to look at and draw from memory. Talk about colours, shades, light and dark, colours we like and don't like. Look at objects through a magnifying glass, Cellophane and water. Dim the lights and then have bright light. Look at objects close to, far away and upside down. Look at pictures in a book, and try to remember them in detail. Play I Spy.

Sound—Begin by listening to soft background music, then loud, fast and slow music. Encourage child to move to music and to talk about how it sounds and how it makes you feel, how you feel like moving. Ask the child to describe and guess sounds on a tape, such as a car, dog, eating crisps, a food mixer, running water, using words like gentle, smooth, grating, harsh. Use musical instruments to introduce rhythm, and to make gentle, loud, scarey or happy music.

Have a blank tape on which we explore tones of voice, angry, sad or excited. Talk about liked and disliked everyday sounds, and imitate them. Talk in gibberish for fun. Replay the tape.

Be aware throughout of the memories that may be recalled and give space to explore these.

Smell—Talk about how we smell. Experiment with breathing through nostrils and feel exhaled air. Smell substances such as coffee, flowers, peppermint, soap powder, onions, curry powder, nutmeg, pepper, garlic, oranges, lemon, perfume, as well as some things that do not smell, such as flour, rice, water, sugar and salt. Pretend to have a cold and to talk about what it is like not to be able to smell. Draw pictures of things with a strong smell, and talk about smells we like and those we don't. Think about outdoor smells such as a bonfire, warm tarmac, petrol, hospitals, flowers. Play a game closing eyes and guessing smells.

Taste—Share a meal, perhaps inviting carer, which includes crisps (salty), a grapefruit (bitter), natural yoghurt (sour), Milky Way (sweet), and talk about the texture and taste of each food.

Experiment with tongue, lips, teeth and cheeks, and describe what each does. Pretend to be a cat and lick up a saucer of milk, and talk about how it feels to lick things. Play a game tasting and guessing foods with eyes closed. Write down or draw foods liked and not liked.

Redgrave (1987) suggests ways of providing sensory experiences for self-healing and enrichment where a child has suffered nurturing deprivation. He believes activities should be freely chosen; play is not directed by the worker except through the provision made. This can include all sorts of water play, play with sand, clay and play dough, outdoor experiences, finger and foot painting, cookery, junk modelling, sounds and music. Brenda Crowe (1974) discusses the value of these kinds of play activities, and their provision and management in pre-schoo! groups. In therapy these activities can fill gaps in experience for older children as well. Play activities may need to be provided in a form which is acceptable to older children, perhaps as cookery rather than dough play, for example, but without the pressure of having to produce an acceptable end product. Similarly, puppets and papier måché may appeal. Some illustrations of sensory play activities in group work with children, by Susan Monson, are found in Chapter 5.

Children in hospital or in other stressful environments may be calmed by listening to soothing sounds and music, such as birdsong or 'womb music' tapes, watching moving patterns of coloured light, receiving gentle massage, or lying in a'soft play' ball pool or on a transparent waterbed with lights playing through it. Snoezelen centres (Walters 1991) originated in Holland (Hulsegge and Verheul 1987). Light projectors, sound equipment, and things to touch and smell provide a whole body sensory experience that can be either relaxing or stimulating according to individual need. These ideas are described further in Chapter 6.

Sensory work allows a child to regress to earlier stages of development, either to compensate for missed experiences or to repair emotional damage. Some children are helped to become stronger in the end by regressing even further, to play with baby toys, to experience contact and comfort through the sensory responsiveness of people and things —laps, cushions, pillows, blankets, soft toys, rocking, to oral comfort through using a baby's bottle or dummy, and to the safe containment of being wrapped up in bedding or a cardboard box. While this often happens in non-directive play therapy it may also take place within focused work, Owen and Curtis (1988) use baby play to give deprived children some understanding of the needs of babies and their own unmet needs at the time, showing why they were not properly cared for as a baby and making it clear that they were not born 'bad'. They suggest providing soft cushions or a mattress to represent the infant's cot, baby equipment such as nappies, bottle, powder, rattle, a teddy or doll to represent a baby, play people, and telephones for communication. The worker puts these among the other toys and leads the child into finding them, and explains that they are things used for caring for a baby. As they play at feeding, changing and rocking a baby, with a teddy or doll or the child itself as the baby, they talk about why it is important for a baby to be held. The worker may say something like 'It was very sad. When you were a tiny baby your mummy had a lot of muddled up feelings inside her which made her tense and she couldn't hold you close' (Owen and Curtis 1988:31). The child has space to talk and express feelings, and to ask questions (to which the worker must know the answers when they concern the child's past).

Sessions may end with cuddling, although some children can only bear a light touch or sitting quietly together, perhaps listening to soft music.

At their best, focused methods can involve a carefully planned series of therapeutic interventions with a child—for example, Sandra Foster's work described in Chapter 5, and Kate Burke's work in Chapter 9. Focused methods are helpful in saving time and shortening therapy, as well as making sure that vital areas of assessment and therapy are covered. Yet they risk rushing children into painful confrontations which they are not ready to handle. Their use needs a trained and sensitive worker who can judge which technique is appropriate to a particular child at a given time. An assessment of the child's developmental level is an essential part of this process.

DEVELOPMENTAL AND BEHAVIOURAL MANAGEMENT PLAY METHODS

All those doing therapeutic work with children need to make an assessment of a child's developmental level in order to decide how to proceed. One approach to therapeutic work with children who are judged to be behind in some or all of their developmental milestones is to use play to help them progress. The main distinction between focused play techniques and developmental play lies less in the actual methods used, which may be the same, but in the rationale behind them. The aim is not so much directly to help children to cope with painful feelings but rather to help children's achievement of appropriate developmental play which will in turn enable them to cope better with the demands of the outside world. There may be a number of possible reasons for children's delayed development, including deprivation, neglect and lack of stimulation, inappropriate parental expectations (whether too high or too low), lack of opportunity or of permission to play, anxiety and emotional disturbance, or physical and mental disabilities, such as autism, or language or learning difficulties. Often it is a combination of these and it may take time to unravel them.

Developmental therapeutic play starts from the stage the child has reached and provides the play experiences needed to help the child to reach the next stage. These play experiences may be broken down into very small steps. For example, a developmentally delayed two-year-old may pick up a cup and pretend to drink but continue to hold teddy upside down by one leg. The adult lets the child see her hold teddy and gives him a drink, saying 'Teddy wants a drink'. She then helps the child to do this, using physical and verbal prompts or backwards and forwards chaining, doing all of the actions except the last or first bit herself and gradually doing less of the sequence as the child does more (Jeffree, McConkey and Hewson 1985, Newson and Hipgrave 1982). By giving help only at the point that it is needed children are enabled to do as much as possible themselves.

Spontaneous play is encouraged. The role of the adult is to be alert to and respond to the child 's play, enjoying play at the child 's level but sometimes offering a play response at a level one step on. The adult is not just an observer but plays with the child. Although the worker is helping the child to achieve apparently physical and cognitive skills, by joining in and responding to spontaneous play, she is also fostering children's view of themselves as active participants with control in play, so developing a positive self-image. A total concentration on teaching the next skill, even when done with the use of praise, risks

stunting emotional growth as children become dependent and passive. Children may need help to learn that play has no serious consequences, that it is all right to make mistakes, that play can be fun. For example, play therapist Bridget Leverton has a teddy who won't stay where he is tidied, or she will pretend to make a mistake, which she and the child can both laugh about. The development of symbolic or pretend play is often a prime need of children with developmental delays. Tumtaking games, such as Peep-bo, help to develop a child's ability to communicate and respond to others. The starting point for these games is often the worker's imitation of the child's action, which leads to the child's imitation of the worker, and eventually to reciprocal play. Parents of young children, where mother and baby play has been unsatisfactory or involved difficulties, can be involved in play, as Chapter 4 on family work will show. Where parents are supported, rather than undermined by 'experts', the benefits to their children's development can be very great.

Behavioural methods

Behavioural methods are sometimes used in developmental play and also in work with emotionally disturbed children. They seem to be particularly favoured by psychologists and some child guidance clinics. Nicol (1988) describes the use of a classical behavioural approach by a clinical psychologist in play therapy with children from abusing families—the 'coercive' family type. Some children's initial responses to the limits of the therapy session were temper tantrums, screaming, destruction, aggression, 'manipulative behaviour' and threats. Their behaviour was ignored or 'when necessary restrained until it died down' (Nicol 1988:706). Constructive and friendly behaviour was rewarded with praise and attention. During the sessions the children, with ages up to 14 years, chose their own play activities from a wide selection of materials: dolls' house, paint, sand, water, trains, cooking, games and puzzles, drawing materials and books. Older children tended to choose drawing, talking or structured games. Symbolic play was encouraged if the child initiated it but interpretation was avoided. Some unobtrusive behaviour modification was used for socially unacceptable behaviour. Where obvious developmental gaps occurred, children were given help in concentrating on a task rather than 'flitting', as well as experience of collaboration, including winning, losing and sharing.

This deliberate use of behavioural methods within play therapy seems to be an unusual intervention and a clear departure from classical play therapy. It accords with Jeffrey's (1981) doubt about the value of aggressive-cathartic play; she felt that perhaps a child needed to learn self-control. However, whilst behavioural methods may be employed to help children to achieve the self-control to make use of play therapy, their continued use puts the worker in an ambivalent and sometimes conflicting position. Axline's non-directive approach is not compatible with an approach where the worker has a hidden agenda. The worker contemplating behavioural approaches has some hard decisions to take.

PLAY TECHNIQUES IN GROUP WORK WITH CHILDREN

There is no single approach to using play with children in groups. Jeffrey (1981) identifies a bewildering variety of play therapies for groups of children: playgroup therapy (for young

children) and activity group therapy (for older ones), therapeutic playgroups, group play therapy, non-directive group therapy, group analytical therapy, transitional groups and activity-interview group psychotherapy.

Structured or focused group play techniques are commonly used when it seems likely that children will benefit from sharing difficult experiences with one another and find that they are not alone. These groups might include, for example, children whose parents are divorcing, a sibling group in a family with problems, sexually abused children, children with a sibling with physical or learning disabilities, or children who have been bereaved. The use of therapeutic play in some of these groups is discussed in later chapters. Playful tasks and games to help children to feel relaxed and comfortable in a group are used initially, followed by specific games to deal with areas which are causing difficulties for the children. Because there is often little spontaneous play the therapeutic value more often comes from the recognition and communication of feelings rather than directly from the play experience itself. The use of play, however, brings a lightness of touch, a playfulness, which fosters open communication.

Activity group therapy tends to involve the provision of play activities in which children's participation is voluntary and relatively unstructured. The aim is usually to help children who have a poor self-image and difficulties in making relationships with other children but who have some give-and-take skills. Through play activities they can channel aggression constructively, perhaps producing a satisfying end product, such as a boat to sail in the bath, and become more able to manage relationships with other children. For example, an eight-year-old boy who found joining a group difficult was encouraged to set up a pretend shop and to play on his own until the worker came in 'shopping' with the rest of the group; he was the centre of attention and interaction was made easy for him (Leverton, unpublished). Activity playgroups are often provided by occupational therapists and nurses in child psychiatric units, or by teachers in classes for maladjusted children. Kolvin (1981) gave an indication of the potential value of playgroup therapy in infant schools with deprived children at risk of emotional disturbance, Hospital play specialists may provide group play activities but with emphasis on helping children to cope with a stay in hospital and the treatments involved.

In Dockar-Drysdaie's (1968b) classic account of therapeutic playgroups at the Mulberry Bush, a residential school for emotionally disturbed children between the ages of five and twelve, she described how she provided separate groups for children according to whether they were integrated or not. Integrated children have had enough primary experience to become containers themselves, and can realize and symbolize what happens to them; they have had a 'good enough' start even if subsequently deprived (see Chapter 1). She provided a group of integrated children with materials for symbolic play, such as dolls and puppets, and play involving communication and games with rules which they could manage and enjoyed. For a group of unintegrated children who needed to be contained, sometimes even physically held, Dockar-Drysdale provided narcissistic and transitional play, with play materials to encourage sensory and regressive play. She responded to children's needs, to be tucked up in a 'nest', to be wrapped up, to be fed, simply allowing them to 'be' if they wished. Although the children were physically in a group there was no expectation that they would behave as members of a group. Their needs were individual and were

individually met. In both groups the role of the adult was crucial, involving the use of Axline's eight principles of non-directive therapy.

Dockar-Drysdale describes a game of Desert Islands which she initiated in a mixed group. The children turned a table upside down for a boat and set sail. They were shipwrecked in a storm and all except one managed to reach the island (a mat), where they stayed until rescued by a passing ship. She writes:

> During this adventure I perched on a table with some of the audience. I said very little except when someone involved me in the drama. There were calls for help from the captain, 'Are you going to let us drown?' I replied that he must feel that no one was helping him. The captain replied,' We've got to do it ourselves!' One of the crew asked me, 'Shall I stay for ever on the island?' I said that it must be difficult to decide whether to go or to stay. One of the audience shouted: 'You've got to decide!'
>
> (Dockar-Drysdale 1968b:149)

In this profound form of play, children's deep problems were safely acted out in symbolic terms, without adult direction. 'Their lives had been stormy voyages; often there had been family shipwrecks: the island had something in common with the therapeutic school which they would one day leave' (Dockar-Drysdale 1968b: 149–50). The Mulberry Bush, which Dockar-Drysdale founded, continues to provide a therapeutic environment for integrated and non-integrated children, dividing them into 'Bigs' and 'Smalls'.

> For 'Smalls' the Mulberry Bush offers a security and containment which is almost womblike. Staff put toothpaste onto their brushes, serve them at mealtimes, brush their hair, bath them and put them to bed… Therapy goes on all the time, everywhere… There are 'nesting boxes' which could double up as space ships, and cupboards with ladders up the sides, for improvised and imaginative games.
>
> (Zwart 1988:8)

Axline, who herself worked with small groups of children, or sometimes pairs of children, noted that one of the difficulties for the therapist is that showing acceptance of one child may be taken as a negative comparison and implied criticism by another child. She suggests that this problem can be avoided if the therapist concentrates on reflecting children's feelings rather than what they are doing. Jenny Senior, taker of Children's Hours, uses children's names to show that each child is reflected equally. She might say,' Jamie wants the horse all to himself, Kate wants to get on; he *still* wants the horse, she *still* wants to get on'.

Group play therapy on the Axline and Dockar-Drysdale models seems to be uncommon in current practice, even in residential schools and homes where it could be more easily organized. Christine Bradley set up a playgroup for children in a residential school for children with physical handicaps. She found that two grownups were needed, one for the integrated children and another to keep in constant emotional contact with two non-integrated children, neither of whom could sustain any activity beyond a few minutes. She decided it was not possible to cater for more than two non-integrated children in a mixed

group. The basic materials were paints, sand, water, dressing-up materials and puppets, although the two sorts of children used them differently. Integrated children acted out internal conflicts and phantasies in pretend play with dolls' families and playing houses, shops and hospitals. The unintegrated children played with simple toys such as soft animals or teddies, curled up in a blanket, listened to stories, or enjoyed blowing bubbles or trickling sand through their fingers. Christine Bradley is currently supporting the work of nurture groups at the Caldecott Community which provide these kinds of primary care activities for severely emotionally damaged children.

Similar psychodynamic principles underlie art therapy which may be provided for groups of children. Emotionally deprived children may find group art therapy a rich and stimulating creative and social experience, a means of sharing and acknowledging one another's creative impulses and feelings, Drama and drama therapy have a similar value. They make use of techniques such as mime, masks, improvization, puppetry, myths and stories, movement and dance, combining therapy with ritual and theatre.

PLAY IN FAMILY WORK

In all the approaches to play discussed so far the focus has been on direct work with children. Often other interventions take place in parallel—for example, counselling or conciliation with parents, planning and preparation for fostering or other placement. The strengths and weaknesses of children's physical and social environments may have been explored and some attempt made to improve them, Most of this work does not involve play. Family work can.

Play in family work has two main strands. One is concerned with supporting the mother-child relationship, promoting attachment and providing 'containment' of the mother (or mother-substitute), meeting her 'child' needs. This kind of work is based on the psychodynamic description of mother-infant relationships, following Bowlby, Klein, Winnicott and Bion, Play work may take place with a mother and child (for example, play for the child in which the mother is involved), with groups of mothers and children together (for example, music with mum groups, or play sessions for several children in which parents are involved), or with groups of mothers (for example, informal play workshops).

Parents may lack sufficient knowledge of how children develop and may have unrealistic expectations, or they may lack skills in managing children's behaviour, Where play methods are used to help parents to acquire knowledge and skills there is a greater possibility of maintaining parents' autonomy and so support their parenting role, rather than when disempowering and undermining didactic methods of instruction are used. Again, play work may take place with individual families (for example, Home Start visiting), with parents and children together (for example, family centre work), or with groups of parents learning together in informal groups (for example, playgroup courses). The use of play in family work is probably greatest in under-fives work.

A different strand of family work involves all the members of a family where there is a problem. Play and games may be used in apparently informal work involving the whole family (for example, in Family Service Units). In more formal family therapy, children's play may be seen as part of the communication occurring between family members in the

therapy session. Often it makes an important contribution to diagnosis of the family problem. Such work is usually based on family systems theory. A child's emotional problem is seen as one indication that some aspects of the way the family works is dysfunctional. There may be faulty communication or a lack of communication between family members, or communication between them may be based on misperceptions or unhelpful family 'rules', The balance of the family may be out of kilter; parents may be too far apart, or the boundaries between generations may not be sufficiently established, perhaps with inappropriate alliances across generation boundaries. In a combination of family systems and psychodynamic theory a child with an emotional problem, who is 'the identified patient', may be seen as carrying the unbearable projected feelings of another family member —that is, the child is scapegoated. Therapy will then try to help each member to take back their projections and to own their own feelings. Introductions to the family systems approach and its variations are found in Gorell Barnes (1984), Jordan (1972), Minuchin (1974 and 1981), Burnham (1986), Walrond-Skinner (1976), Satir (1964), Skynner and Cleese (1983), and Carpenter and Treacher (1989).

Child guidance and child psychiatric units are most likely to use a family systems approach. Conciliation work with families in divorce is a newer area of this work in which the family's break-up is recognized and parents are helped to understand their children's feelings and to make the best possible arrangements for the future. Play is used to help children both to express and communicate their feelings. Because family work differs in important respects from much direct work with children it will be discussed separately in Chapter 4.

CONCLUSION

This chapter has shown that there are differing approaches to using therapeutic play in work with children and families. Yet there are some essential qualities which distinguish play therapy from other kinds of help. Play therapy works because play is children's natural means of expressing, communicating and coping with feelings. It depends on the healing power of spontaneous creative play in which the child 'surprises himself or herself. The therapist or worker provides the play setting within safe boundaries which makes this healing play possible, offering the child a 'containing' relationship, a mental space in which the child's anxieties can be borne and thought about. Attentiveness and reflective listening are the worker's most powerful tools.

To determine whether individual play therapy is an appropriate invervention there needs to be a thorough assessment involving all relevant agencies. Family work and family therapy, or group work, may be more appropriate. Therapeutic play may be an important part of these other interventions, as Chapter 4 will show. Often play therapy with a child is carried out alongside some other form of work with the family. The necessity for this is suggested in Nicol's (1988) research which indicated that play therapy alone was little help to children in 'coercive' abusing families where attitudes to the child remained unchanged.

While there is little research into the effectiveness of play therapy, numerous case studies bear witness to the power of play in healing the hurt child. The next chapter is designed to help the worker to prepare to use play therapy in individual work with children.