

Play Technique in Psychodynamic Psychotherapy

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KEYWORDS

• Play • Play therapy • Psychodynamic psychotherapy • Metaphor

KEY POINTS

- Imaginary play is often the best way children have of communicating their affects, internal states, fantasies, and complicated conceptual understandings of themselves and the world.
- The opposite of play is not work but reality; and in pretend, children are considerably freer to express conflicted or forbidden aspects of their feelings and their stories.
- We must always be cautious about reading play material as having a one-to-one correspondence with what the child has actually seen, done, or experienced.
- One of the best ways to enter the child's world is to speak to the child from within the frame of the play displacement. Interpreting the unconscious meaning of the play material directly, may shut down the play process.
- Rather than finding the meaning of a particular piece of play, it is often the ability of the therapist to help the child to continue to elaborate different meanings that is the most useful therapeutic technique.
- Today we think of the play as a process that is coconstructed between patient and therapist, and think of the therapist as a participant in the process as well as an observer.

Every child at play behaves like a creative writer, in that he creates a world of his own, or, rather, rearranges the things of his world in a new way which pleases him. (Freud, 1908).¹

INTRODUCTION

Play in its broadest sense refers to a wide variety of activities that are universal in human beings of all ages and in many juvenile animal species.² This article, however, uses the term “play” to refer to a particular kind of play: imaginary or pretend play. Pretend play has its own developmental trajectory,^{2–4} occurs naturally in young children, and is an important factor in their cognitive and social development. Imaginary

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play reaches its peak during the years of early childhood, approximately from age 3 to 7 years. Clinicians who work with children have long used the child's natural capacity to engage in imaginative play as a means of gaining access to the child's inner world, a "royal road to the unconscious." Such is the kind of symbolic play referred to when talking about "play therapy" or "play technique."

Developmental researchers have also studied pretend play for many years in a separate context. Investigators have been interested in play from the perspective of learning about children's cognitive development, organizational level, and their ability to understand another's subjectivity.^{5,6} Both psychoanalytic and developmental perspectives may be used in an integrated way to understand how pretend play can unfold and be therapeutic in a clinical setting.⁵

Although play in normal development may have a critical period,² in the therapist's playroom, pretend play can be therapeutically effective not only with young children but with children of all ages. This success is often achieved by increasing the frequency of therapy sessions per week and by using the techniques of pretend play in combination with the use of more structured games, music, drawing, and other creative materials. The therapist must actively engage the child in play and scaffold the play when necessary.

WHY PLAY?

Play is privileged as a clinical technique in working psychodynamically with children because it is often the best way children have of communicating internal states, fantasies, affects, and complicated conceptual understandings of themselves and their relationship to the world. Play is also privileged because many believe it is therapeutic in its own right, helping the child to gain developmental capacities that have lagged behind. In development the capacity to play is part of a complicated developmental process. Its emergence has a pivotal place among several developing capacities in the young child, including an explosion of language, the emergence of symbolic functioning, reality testing, triadic relating, and the development of a theory of mind.

Play is Pretend

One of the most important defining characteristics of imaginary play is that it is not real.^{1,7} The opposite of play is not work; it is reality.⁷ Engaging in pretend play invites an intense affective participation and collaboration with a child in an enterprise that is safe and permissible precisely because it is pretend. Because it is pretend, children are considerably freer to express conflicted or forbidden aspects of themselves and their stories. Children at play are not the monsters, bad guys, or dinosaurs that destroy the world; nor are they the small, helpless creatures that are being attacked^{8,9}; they are taking on a role, which can be abandoned or exchanged at will. Important wishes can be expressed without contending with consequences, either from the side of reality or from the side of the superego.⁷ The capacity to play can facilitate an exploratory and deepening therapeutic process because it allows access to parts of the self that are not consciously available, parts that are consciously disavowed or repudiated.

There is paradox in playing. Although play is at once "as if" and "not real," it simultaneously involves an intense emotional engagement with the therapist that feels, and is, affectively alive and "authentic."^{8,9} There are also similar aspects of this kind of paradox and oscillation in adult psychoanalysis and psychotherapy, especially when working with the complex state of transference or when using free association.¹⁰

Children who are fully engaged in play, whether inside or outside of therapy, enter a modified ego state or state of consciousness in which attention, perceptions, and

thought processes are altered and are redirected primarily to internal experience and fantasy.² When things are going well in therapy, the child and therapist can be in both worlds at once, the real world and the world of the imagination, and can fluidly move back and forth. There are always moments, however, when the paradox collapses, when what is enacted becomes “too real” for either the child or the therapist. In these moments the frame of the play collapses, and the parties have to regroup and renegotiate. In these moments the frame of play has failed to contain the affective struggle of the participants.

Play Consists of Actions and Words

One reason that play is such an effective therapeutic technical tool is that children, especially young children, do not use language in the sophisticated ways adults do. Children often communicate with their whole bodies in action rather than in words. If they feel shame, they will hide. If they feel needy, they will use up all the paper supplies in the playroom. Children will tell you how close they want to be to you by moving closer or further away in physical space. Strong affects, in particular, are not easy for children to articulate in words. In fact the therapist’s ability, like the parents’, to help children name feelings and put their impulses into words is a major contribution in enabling children to eventually contain their feelings, self-regulate, and delay action and impulses. Play in the clinical setting has a similar self-regulating function.

Even when a young child is eager to communicate in words, words may not be the best means of expressing abstract concepts such as emotions. If you ask a young child how she feels, she will often respond with a stereotyped answer such as “I feel happy” or “I feel sad.” If you want to get a more nuanced response, you must ask the child a question like, “what happened then?” Such a question will structure the response in the form of a narrative.¹¹ Pretend play relies on a narrative structure, and it is often the detail of the story that will convey the emotional subtext. When a 3-year-old patient, Jonathan, repeatedly threw the boy doll in the trash basket, it was clear that he was expressing his sense that he could, would, or should be thrown away, and that he felt worthless and bad, like garbage. He could never have expressed this in words.

Play is Metaphorical

It is also important to note that play, like language, uses conceptual metaphor. Lakoff and Johnson^{12–14} and other cognitive linguists have revolutionized our thinking by redefining “metaphor,” not as a figure of speech but as a fundamental mode of human thought. These linguists believe that metaphor is a nonconscious (different from the dynamic unconscious) way of thinking used by human beings to categorize their experience. Modell,¹⁵ like Lakoff and Johnson, defines metaphor as a “mapping or transfer of meaning across dissimilar domains.” The transfer goes from a domain in which there is much concrete knowledge to a domain that is abstract, complex, and much more difficult to define. Lakoff and Johnson¹² use the example “love is a journey” to explain conceptual metaphor in language. In this example, love is a concept that is intrinsically difficult to define and, therefore, is almost always defined in terms of something else; in this case it is compared with a journey, something very concrete. When one says about a love relationship that it “is on the rocks” or that “we can’t turn back now,” the listener knows immediately what is meant, because of the implicit conceptual metaphor that is part of our everyday thought process. Imaginary play uses conceptual metaphor, just as language does, to categorize experience. In fact, Lakoff and Johnson¹² believe that the ability to use conceptual metaphor may be separate from and antecedent to language.

Clinical example of how play communicates complex conceptual material

Ryan, a 5-year-old boy with a great deal of emotional dysregulation, played out the following story during a therapy hour. A family of plasticine people was at home in the living room. "ET" knocked at the door. ET was "from another planet" and was represented by a plasticine figure with 2 heads and a tail that looked "weird." Ryan told me that ET was an orphan, a "baby orphan," who wanted the family to help him. I was directed to play the part of the family. Under Ryan's direction, the family agreed to help ET and gave him food, but ET ate up all of the family's food. He took the family's car, and drove it until it crashed. He ignored the rules. ET spoke a different language and therefore could not understand the family's rules. He could not control himself and destroyed the family's house. Finally, while trying to fly, he fell off a cliff into a deep pit. At this moment, in a kind of frenzy, Ryan tore ET apart, pulling off his legs, arms, hands, tail, and heads, until the extraterrestrial was just a pile of body parts. Ryan began to toss them into the air and scatter them.

In this imaginative, well-constructed play narrative, Ryan was able to express something very important about how he felt. It was a representation of an inner state whereby feelings were "too big" and threatened to get out of control. Ryan certainly could not have expressed this in words alone. As a young child, he did not have the conceptual language to do this. Yet by using several universal conceptual metaphors as part of his play, Ryan communicated metaphorically his sense of feeling alone (an orphan), insignificant (little, a baby), and different (alien). He also conveyed his sense of feeling internally precarious, uncontained, and coming apart. Most poignantly, at the end of the play sequence, Ryan made ET fragment completely, conveying a lack of self-cohesion. Adults might characterize such a state of mind in a very similar way, using verbal metaphors such as "I feel like I am going to pieces," "I'm falling apart," or "my mind has snapped." Again these universal conceptual metaphors compare an abstract state of mind with a concrete physical object that is brittle and can break.¹² Ryan's communication conveys this state of mind metaphorically in play, rather than words, but in a way that is equally accessible.

Play is a Process

Children have various capacities to play. Children, like Ryan, who have a good play capacity find play pleasurable, and feel safe in communicating their feelings and ideas in play to their therapists, particularly if their therapists make a safe play space and respect their defenses and the use of displacement, which is a main feature of play. For children with a good play capacity, the imaginary play has a process that evolves over the course of treatment. The play has a momentum. It is pleasurable. Over time, an increased degree of complexity is expressed. An increased range of affects is tolerated. An increased elaboration of fantasy emerges, liberating what is being represented from the constraints of both reality and superego. Metaphors evolve, change, and transform. New narratives, solutions, and compromise formations emerge. All of these factors can be used as markers of the treatment process, although there may be periods of regression or impasse, as in any therapy.

THE THERAPIST'S INTERVENTIONS

Listening to Play

Play does not have one meaning: it operates at multiple levels.

Play is complex. Like any communication, it can be read and understood on multiple levels. Play can be the child's representation of an experience from the historical past or a representation of a current life experience that he or she is trying to integrate. Play

can be an expression of a child's fears and fantasies, or an imagined solution. Play can be a reenactment or a creative representation of an aspect of an important formative relationship, a phenomenon we would commonly label transference. Play can also be the child's imagined account of what is happening in the new, present relationship with the therapist, a contact through which the child always hopes to find a better, more satisfying way to engage.¹⁶ All these different levels of meaning are oscillating in the play material at any given moment. One must always be cautious, however, about reading play material as having a one-to-one correspondence with what the child has actually seen, done, or experienced (**Box 1**).¹⁷

The therapist is listening at her best when she can recognize and resonate with the many different levels of meaning that are evolving in the shared play space, but this is difficult to do. Some meanings will feel more salient than others; some will be more elusive. However, an appreciation that the play material does not have one concrete meaning, nor does it operate at one level, is an important place for the therapist to begin. Rather than finding one overarching meaning of a particular piece of play, it is often the ability of the therapist to help the child to continue to elaborate different meanings that is the most useful therapeutic technique. It is also helpful to remember that within a given session the different behaviors and play fragments that occur will always have connecting links, even when the continuity is not obvious. There is always a tension between the goals of communicating a particular insight or understanding to the child and keeping the play space open for further elaboration, to continue to make new meanings. Often interpretations, even when right, can reduce the play to one particular level of meaning, the one that is the most obvious in the moment.

Example of Listening on Different Levels

Let us go back to the example. Ryan expressed in a very nuanced way something about his internal state. As his desires and demands escalated, it felt as if neither he nor his environment could contain them. Under the internal sway of such urgent needs for more food (nurturance, comfort) and more stimulation, no one would remain intact. Furthermore, there was no way of resolving this dilemma, because everyone spoke a different language and no one could understand the other.

As the therapist, I (J.A.Y., the author of this article) could have read Ryan's play communication in different ways. I could have recognized his play as a representation of his real world; that is, a story about a home in which limits or containment were missing or inconsistent, a reading that might be more or less accurate. Or I could have understood his story as a representation of the way he saw himself or was perceived by his parents. In such a reading, I might imagine that Ryan envisioned himself as a child who was so "different" that he felt like he was from another planet, a child that no family could rein in or keep safe. Another way of listening to the play

Box 1

Play communicates on multiple levels

1. Play can represent an experience from the patient's past
2. Play can represent current life experiences
3. Play can express fears, fantasies, and imagined solutions to conflicts
4. Play can reenact aspects of important formative relationships (transference)
5. Play can represent the patient's representations of the new, present relationship with the therapist

communication was that it reflected something about my relationship with Ryan in the moment. He might have been telling me that he was feeling uncontained and unheld by me because of something I was doing or not doing. Or the play might reveal his wish to “move in” with me so that I could be his new, idealized “adoptive” family. Ryan might have been trying to discover how I would respond to his escalating excitement and unruly behavior, perhaps both recreating the past (transference) and hoping for a different outcome (new object). Finally, the play might have been a representation of Ryan’s internal landscape in which “ET” represented one part of himself (the powerful, aggressive, and thrill-seeking part), whereas “the family” represented another part: an internalized set of rules or values, difficult to adhere to when in conflict with the pleasure-seeking or anxiety-laden impulses. These different ways of understanding the play material might all have been relevant; however, they may not have all been equally salient.

The therapist must determine what aspects of the play are most important, and that will determine how she chooses to respond. Play always occurs in a particular context, never in isolation. Therapists listen on the basis of what they know about the child, their experience with the child, and their experience of the family. Therapists listen with an ear to normal developmental crises or impasses; listen to what the play makes them feel, their countertransference; and listen to how the story is being communicated as well as to the content of the story. It is especially helpful to listen with the following question in mind: “why is the child telling me this story at this particular time?” This question inevitably leads to a curiosity about where the therapist is located in the story, as well as what is now happening in the patient’s real life. The following questions immediately come to mind: Is something going on in the therapeutic relationship? Have I been away? What happened in our previous session? Did Ryan get into trouble with a teacher or his mom that day? Children are much more likely than adults to have upsetting experiences at home or school spill over into their therapy sessions.

Working Within the Play Displacement

The unconscious content of the play may often be easy for the therapist to understand, especially if the play has a clear narrative arc and is well structured. However, simply interpreting the play as a statement about the child (a child’s wish or fantasy, or representation of reality), even if right, might easily shut down the play space, thus running counter to the child’s assumption that his play is pretend and is being received by the therapist as such. Children make this assumption for different reasons. Very young children (younger than 5 years) have no clear cognitive recognition that their play and their internal thoughts are related,⁴ whereas for older children the displacement of play makes it a protected place. Older children, even when they understand that their own minds and intentions are at work in creating play, use play defensively to keep themselves from experiencing the potential consequences of reality or conscience. Therefore, timing is everything. One interprets directly from the play only when one thinks that the child is already very close to knowing that the content of the play is about himself and when he is not too defended to hear it.

For instance, if I said to Ryan, “you are so angry you feel like breaking your house apart,” he might easily feel accused, frightened, or misunderstood. He might temporarily close down the rich play space that he has just created with me. Disrupting the play space is a frequent, inadvertent consequence of going directly for unconscious forbidden wishes, overriding the patient’s defenses, and quickly attributing these wishes directly to the child, as in this example. This kind of direct interpretation might well miss the nuance in Ryan’s communication as well. For instance, Ryan does not

simply want to break down his house, he also wants to be contained by the family because he is afraid of these destructive wishes. He may even want to be punished because he feels guilty about them.

One of the best ways for the therapist to enter the child's world and to communicate is to do this from within the displacement of the play.^{18,19} These kinds of interventions respect the frame of the play. The therapist can comment (1) from outside the play about the play as an observer, still using the patient's play metaphor; or (2) from inside the play as one of the characters in the patient's story. The therapist can even create a new character or tell a related story (**Box 2**).

In the first kind of intervention, the therapist uses her own voice to tell the child what she observes in the play, or to ask for an explanation about the play. For example, the therapist can say to Ryan, as an observer from the outside, "the family doesn't seem to have enough food to keep ET from feeling hungry, what should they do?" or "ET has been starving for so long that he cannot get enough food to fill him up." Each of these comments emphasizes a slightly different aspect of the story; each represents an aspect that the therapist might want to develop for the future. What is technically important about this type of intervention is that even though the therapist speaks from outside the play, her comments respect the displacement of the play, its frame. She does not talk about the child directly. It is ET who cannot be filled, not the child. Such a voice can be comforting because the therapist "gets it," helps contain the affective tension, shows interest, or functions as a witness to the child's communication. Such a technique can feel safer to a child who is not ready to have a true play partner.

The therapist can also talk from inside the play, from the point of view of a character. For instance, as the father I could say, "My gosh, ET is still eating and we are running out of food! What should we do?" or "It looks like he hasn't had any food in days! He is starving!" Talking from inside the play as one of the characters is certainly more playful. The therapist is freer to use her own person to play a role; she can inject more affect into the story and can use voices other than her own. The patient has to have the play skills to respond to this "other" voice, which introduces something different. For example, it is not infrequent for the therapist to express, through her character, a part of the child that the child has disavowed and, therefore, remains unrepresented in the narrative. In Ryan's story this was not the case, as he represented both sides of his conflict: ET felt excited and powerfully strong, as well as frightened of being out of control. However, if Ryan had not been able to represent both sides, the therapist might have chosen to represent the unspoken part—the fear, for instance—through an invented play character. The patient would then have the option of taking in or rejecting the therapist's introduced perspective. Ryan might say, "no, he doesn't say that!" This would tell me that he is not at this moment ready to engage with that aspect of himself. As long as the therapist introduces things in pretend, the child can decide if these things are irrelevant, facilitating, too threatening or, in fact,

Box 2

Working in the displacement

1. The therapist can comment about the play from outside, as an observer, still using the patient's play metaphor
2. The therapist can comment from inside the play as one of the characters in the patient's story
3. The therapist can comment by creating a new character or by telling a related story

transformative ways of telling his story. This is also how play works in social situations with peers; it is negotiated. Although the child's story must always be salient, the therapist is more than an observer in the play process; she is a participant/observer, meaning that she must be particularly observant about the impact of her interventions.

It used to be a "rule" among analysts conducting play therapy to only take one's cue from the child, and not to elaborate any part of the story unless the patient had given the therapist explicit directions to do so. I have found this "rule" to be overly cautious in children who have a good capacity to play, and inadequate in children who need help in learning to play. This cautionary rule came from a time when child analytical technique was supposed to look like adult analytical technique, and when adult analysis was considered to be an unfolding of something from inside the patient. There was a concern that anything from the analyst would contaminate the field or the process. Today we think of play as a process that is coconstructed between patient and therapist, and think of the therapist as a participant in the process as well as an observer. The therapist's participation helps the child to scaffold and expand the play.

In fact, the play was not simply a one-way communication from Ryan to me about his experience or state of mind. I communicated something to Ryan about how I contained and dealt with my feelings, particularly my difficulty in having impact, because my "rules" could not keep ET or the family safe. However, when Ryan started to pull ET apart and scatter the small plasticine pieces all over the room, I said in the pretend voice of the father with my full adult authority, "pull yourself together, son." Although I stayed in the play metaphor, I also responded in action, by the tone of my voice and by gently covering what was left of the unthrown pieces with my hand. I regulated the play downwards. This scenario was not thought out; it simply happened. Ryan's plea for containment in the story was now responded to by my "real" containment, via an enactment in the playroom.

Turning Passive into Active

One of the most important therapeutic consequences of pretend play in both natural and clinical settings is that it allows the child to have mastery over situations that are experienced passively and that are uncomfortable or traumatic. Freud¹ understood this, as did Waelder,²⁰ who described how play helps the child rework difficult experiences by metabolizing, mastering, and assimilating them.

Clinical example of listening, working within the displacement, and turning passive into active

A 5-year-old boy came to my office and acted out a particular story. He played the same story every time he came to see me. In a way it was the same story, but it was always a little bit different. In this story he was "Joe," a deep-sea diver, who had to plumb the ocean's depths and check the ocean floor for signs of trouble. The trouble was usually of an environmental nature, a certain species of fish was about to become extinct or was about to take over another's territory. Joe was the ocean's fix-it man. He would start out on my couch, outfitting himself with a diving suit and something suggestive of an oxygen supply. He would then roll himself over the side of the couch, and swim away into dark and deep waters. But the sea was a very dangerous place, and when he left the safety of the boat, Joe had to make his way among man-eating sharks that could bite off his legs, stingrays that could "paralyze his bones," and, above all, he had to avoid the entangling arms of a giant octopus.

I was Mike, Joe's partner, and my job was to stay up on the boat and monitor his comings and goings on a computer screen. The screen allowed me to be aware of all the dangers that were about to befall him, even the ones he had not yet come upon. I could communicate to him by special underwater cell phone and warn him what lay hidden around the bend. In this way,

I could keep him safe. However, sometimes I wasn't paying attention, and my warnings came too late. Or sometimes he wasn't paying attention, and wandered off beyond our signal area. Then he was in deep trouble. He had to fight off vicious creatures alone and bare-handed. Joe was a skilled and powerful fighter, though, so in the end he always escaped just in the nick of time. Then he would text, "pull me up!" and I would reel him in like a big fish. He would flop down in the boat, breathless from his adventure, and sleep. I would have to tuck him in. Sometimes he would dream about the ocean.

As you can see, Joe's play was very well constructed and coherent for a 5-year-old, an indication that he had a well-developed play capacity and many ego strengths. Knowing something about his history made his play particularly meaningful. In real life "Joe" was an only child. In fact, he was a long-awaited child, as his parents had difficulty conceiving after many miscarriages. From infancy on, he had some very potent allergies. As a toddler he had suddenly become life-threateningly ill when he was inadvertently exposed to one of these allergens. He had to rely on the vigilance of his parents to keep him safe, and they had to be unusually attentive. He became very anxious when they were not around, and they also worried about his venturing forth into the world without them, although they also wanted him to be strong and independent.

In his play, Joe created a wonderful metaphor for his psychic experience. He created an ocean world that had many of the characteristics of his real world. In his ocean world, there were many perilous things that were "ordinary" for the ocean but that had to be avoided by him. There were also many things that were not working the way they should be working, and needed fixing. He knew that he needed to venture forth on his own, but this was very dangerous. In his play, he created a meaningful way of communicating his inner experience to me so that he was no longer alone. Through his play he found a way to make his overwhelming feelings a little more tolerable. He also found a way of incrementally metabolizing his experience piecemeal to find new adaptations and solutions. A major mechanism in the play for doing this was to turn passive into active. In his story he wasn't the littlest one in his family; he was Joe, the grown-up fix-it man. He was, big, strong, and powerful; he was not helpless. He was master of his destiny.

The traumatic aspect of this boy's history made this recurring narrative the focus of his treatment for a long time. However, despite the repetitive nature of this game, it never became stereotyped and inert as it might have become for children whose play is more traumatically stuck. New things were always being added to his play, and new metaphors were always being created, with the potential for finding new solutions.

This play, of course, included much more than simply a mechanism of turning passive into active. It provided a way for exploring the complicated nature of his relationships with the adults in his life. Joe was trying to come to grips with his relationship to his parents, as all children of this age are trying to do. The idealized parents were supposed to magically protect Joe from harm and were supposed to foresee every danger, even dangers that he could not see. Joe's parents were not always able to do this, which made them, at times, disappointing to Joe. It also made him and them very anxious because life could be so unpredictable. His parents were still the main focus of his life, and moving away from them seemed especially difficult for both Joe and them because of fears for his survival. He was young and the world felt particularly dangerous. In the transference I was both an idealized and disappointing parent. Joe wanted me on the boat, at a distance, but connected at all times by a computer monitor and an umbilical rope.

The play also provided a metaphoric way of looking at unconscious conflict and fantasy. Going down, according to Lakoff and Johnson,¹² is a universal metaphor for being further away from awareness, consciousness, or wakefulness. The dangers that were present on the ocean floor were evocative of typical developmental conflicts and concerns that a 5-year-old boy might have. Joe wanted to explore what troubled him, but his mind also felt dangerous to him. In many of his pretend "outings," Joe deliberated between 2 specific dangers: swimming near a man-eating shark that could bite off his legs or getting too close to a giant octopus that could grab him, never to let him go. Joe had unconscious conflict about growing up, made somewhat more difficult by his history. Joe adored his mother, but often held on to behaviors that kept him very babyish. By staying his mother's baby and refusing to grow up, he succeeded in getting her attention and at the same time avoided being a competitive threat to his father. However, when Joe remained a baby he did not feel competent and successful in the world, and feared he could get stuck with his mother forever. In Joe's play he had to fight both fears: the fear of retaliation for his wish for an Oedipal victory (the castrating shark) and his fear of his regressive urges (the entangling octopus). Joe used his play in a very productive way to explore these fears and conflicts about growing up. Through his relationship with me in the transference, he played out his urges to be independent, admired, rescued, babied, disappointed, angry, and competitive.

Transference and Countertransference

Different children use the therapist in different ways, according to their predominant needs. All therapeutic relationships carry vestiges of past relationships; we call this transference. At the same time the repeating and reworking of the past comes in the context of a new relationship in which there is the possibility for a different outcome. Because children are always in the midst of an important developmental process while they are in therapy, many believe that their experience with the therapist is internalized in a more influential, comprehensive, and enduring way than it would be if the developmental process were completed.^{21,22}

Children inevitably play out and reenact aspects of their primary relationships with their therapists, just as adults do. Being able to recognize when and how transference is occurring is an important aspect of understanding children and their conflicts, and is an important aspect in communicating with them.

Some argue that transference is not as prevalent in children as in adults because the therapist also has an important role as a "new object" or a "developmental object."²¹⁻²⁶ Because the child is in the midst of development, it is surmised that the therapist is used by the child to fill current developmental needs. Others argue that if the therapist does not take a moral position with the child and does not act as a substitute parent or an educator, but instead maintains neutrality and analyzes the interactions that arise between patient and therapist, one can work in the transference with children in a similar way to the way that one does with adults.²⁷⁻²⁹ Although transference is always present, transference reactions are more likely to cohere and consolidate when the therapist is seeing the child more intensively.

Children often do not understand the concept of transference in the way that adults do; that is, they do not understand its "as if" nature.³⁰ When children feel something about the therapist, they feel it in the present moment and it seems very "real" to them, and often very "big." Rarely do they understand that the strength of their feelings exists because the therapeutic relationship has triggered something from their past or from their current family lives. Because it is difficult for children to comprehend the paradoxical nature of transference, it makes sense to address what is happening between child and therapist in the present and to understand it in the moment.

Often transferences are manifest in the play itself, as they were with Ryan and Joe. Ryan's fear that he would be seen as uncontrollable by his family and Joe's difficulty titrating dependence and independence were important aspects of their relationships with their parents, and they became important in the play interactions with me. These transference feelings led to ways of relating to me that were expressed, enacted, and "played with" in displacement in the play. I did not directly address how the play related to their real lives, because I believed that we were working on these issues productively in play. Nevertheless, I kept the idea of transference very much in mind as I listened.

Sometimes it *is* important to take up transference directly with a child, especially if strong emotions are interfering with the therapeutic work. When children arouse a great deal of feeling in us because of the aggression, hatred, seduction, or neediness that is directed at us, we can almost always be sure that the child is replaying elements of a primary relationship. Nevertheless, it is difficult not to take these strong feelings personally. Interactions around the frame are a very common place for the arousal of transference feelings directed at the therapist to be found. Children may be frightened of entering, or refuse to leave the session; they may be angry in sessions before or after a vacation, and may not want to come back to therapy. Children may feel envious of the toys we have and may want to destroy them, trash the playroom, or use up all our supplies; they may even attack us physically. If they like us too much, they might experience this as a conflict over loyalty owed to a parent. Parents have strong transference feelings to us as well.

Children are often able to acknowledge their intense feelings in the moment, even though they have no appreciation that their sense of abandonment, jealousy, envy, or disappointment has its origins in some previous relationship. Their feelings are best addressed in terms of what they feel in the present coupled with our understanding of what has immediately precipitated this reaction. "You got upset when I told you that our time was up, and then you threw over the box of markers. Maybe you thought I was saying I didn't want to be with you." There are often clear triggers in the therapist's behavior that have contributed to the rupture between therapist and child, and these can also be acknowledged. The therapist may not have been paying attention, or she may have said something that the child found hurtful.

Because children tend to enact their feelings rather than talk about them, the therapist will have to set clear limits to make the play space safe for herself and the child so that the child does not feel too anxious or guilty about what he has enacted. On the other hand, there is always a balance between keeping behavior safe and nondestructive, and wanting to understand what the child is trying to express in action. Therapy has to be a place where the child can express his feelings, even if they are not very pleasant ones. Often things get better on the outside when the "bad" behavior that brought the child to treatment comes into the sessions. For instance, although I do not allow children to destroy my toys or hit me, sometimes it happens that they do, which in turn becomes an opportunity for therapeutic understanding.

Particularly obvious manifestations of transference are those behaviors that concern the child patient's reactions to the presence of other children in the office or waiting room. These other patients who share the therapist's time represent siblings, about whom child patients often have strong and particular feelings. One patient of mine was convinced that the things in her special box had been disturbed or stolen by another child when she was away from the office, even though this was not in the least true. She had felt very deprived by the birth of her sibling some years back, whose arrival coincided with the loss of a favorite nanny. In her mind, all the things that she had lost seemed taken by the birth of this sister. We often addressed and elaborated her fears about losing the things in her special box and her fear that

I could not keep them safe, as well as her own wishes to look in everyone else's box. Although her history and jealousy of her sister were known to her, the issue about losing her place with me was a much more viable way to work on the past. Nor would she have necessarily understood that my other patients were "stand-ins" for her sister.

Whenever a child asks about the therapist's age, or where she lives, or if she has children or not, there is always a fantasy lurking in the question. It can often be very helpful to address the child's underlying concern or interest, whether one answers the question directly or not. The therapist might say: "you are very curious about what I am doing when I am not in this office"; or "you are wondering who I am with when I am not seeing you"; or "you are wondering if I am a mother, and what kind of a mother I would be."

Children who Cannot Play

Many children whom we see in evaluation and later in therapy cannot use imaginative play, and this occurs for many different reasons.³¹ The capacity to play is an ego capacity that is important to assess when we evaluate a child.

Children who have autism or are on the spectrum for pervasive developmental disorders (PDD) often cannot play pretend, because they cannot play symbolically.^{32,33} It is thought that this deficit is complex, but largely biological in nature; these children have great difficulty developing a robust theory of mind. Play techniques have been developed specifically for working with these children, emphasizing a foundation of shared attention and engagement.³⁴ Although we know that play is universal in human development, we also know that it is highly susceptible to the impact of environmental factors such as trauma, troubled attachment, and even nutrition.^{2,35,36} Research shows that children who are securely attached by age 3 years are 3 times more likely to play pretend with their peers than children who are not.^{36,37} Children in secure relationships with their caretakers tend to be interested in using toys, playing pretend, and exploring the world because of their primary investment and identification with their parents who introduce these interests to their children, while providing a secure base. Preschool children with disorganized attachment, on the other hand, are more likely to completely inhibit fantasy play or act out chaotic, violent fantasies that have no play resolution.^{36,38,39} Children cannot play when they cannot coherently organize their experience.

Children who have suffered severe trauma are another group of children whose play is impaired. The play of traumatized children is often stuck in rigid and repetitive forms that seem to go nowhere. The play may actually be communicating some aspect of the trauma in a concrete way while simultaneously interfering with the development of a creative, coherent narrative. Working with this kind of traumatic play may be arduous, but incremental changes are important signs of progress.

We also see children who have difficulty playing because they have internal conflict and play inhibitions. Sometimes these children can play pretend at home quite well but do not want to play with their therapist because it feels too revealing. For children who are frightened of their feelings and thoughts, the freedom of pretend can feel less safe than a structured board game because internal thoughts and feelings can "pop out" without warning or control.

Clinical example of a child unable to play

I worked with an 8-year-old boy who was inhibited and very anxious about his impulses. David refused all my many attempts at pretend play. He was a chess whiz and only wanted to play chess and defeat me at this game until he felt safer. David eventually became an excellent

pretend player, but only after a long time and only when we began to meet multiple times a week. The inroad to pretend play occurred one day when I had been particularly frustrated about losing a chess game to him once again. In a pretend voice, full of real frustration, my king began to complain that he was totally fed up because no one in his kingdom was doing their job to protect him and that he was tired of having so few moves. He always felt “boxed in.” Although David usually rejected my use of pretend and playfulness, on this day he answered the king and gave him some important advice that opened up a completely different level of play, the beginning of fantasy play. Perhaps the element of revealing my authentic frustration, alongside David’s identification with the king’s sentiments and my perseverance over time, brought about a different response.

HOW THE CHILD PLAYS

When a child is a “good player” the therapist has a much easier time finding a way to engage, enjoy, and facilitate the deepening of the play. The therapist has more degrees of freedom in terms of what can be addressed and in what forms it can be addressed. Every child/therapist pair develops their own play process that is unique to the dyad and has their fingerprint on it. With children who have more difficulty playing, the therapist’s skill in facilitating the process and engaging in play will be more crucial. Of course, it is not simply play that the therapist is interested in. The use of language, action, particular words, interruptions of play, the expression of affect or lack thereof, somatic events, facial expressions, gestures, and eye contact are all part of what the therapist will use to understand and make meaning with the child. Much of what I have talked about so far is the aspect of the play that is in symbolic, narrative form, but there are also many aspects that are delivered in action and are communicated in nonsymbolic ways.

Play Disruptions

Play disruptions⁴⁰ occur when too much anxiety arises from a conflict during play, with the play being interrupted by the child.

Clinical example of disruption of imaginary play

Suki, an 8-year-old girl who had a very ambivalent relationship with her mother, played out the story of a polar bear family with small animal figures. The bears split up to find food. The father and daughter bear went in one direction; the mother and baby in the other. The father and daughter had great success and stuffed themselves, as if at a delicious banquet. The mother and son faced a vanishing food supply, wandered and wandered, and soon began to starve. At this point in the story, Suki got ashen and said “this story could not really happen,” and put away the toy animals because playing pretend was “too babyish.”

Suki got anxious at the point in the story when her fantasy of Oedipal victory and her aggressive impulses toward mother and baby became “too real” and too threatening. She anxiously stopped the game, reminding herself that it could not really happen. In a similar way, children can interrupt the play by needing to use the bathroom, by insisting on visiting their mothers in the waiting room, or by being unable to continue the narrative arc of the story. Sometimes the play disruption takes the form of shutting down the play, as it did with Suki. At other times the disruption takes the form of enacting the impulse, as when Ryan began to scatter the Lego pieces all over the room or when a child suddenly hits the therapist instead of the mother

doll. The play disruption can also involve a somatic discharge such as soiling. Noting what occurred before the play was disrupted is of critical importance to the therapist in understanding the nature of the child's conflict and what got in the way of playing.

The therapist has several options in dealing with play disruption. The therapist can observe it but not address it, or can point out to the child that the disruption happened in response to something that worried her (a form of defense interpretation). If Suki were receptive, the therapist might say something about the impulse that actually made her so anxious: "you began to worry what would happen to the mother bear because she got too close to starving."

The therapist wants to be able to contain the child's fantasies, conflicts, and difficult emotions, and to use play to explore and organize as much about the child's inner affective life as the child can manage. The therapist is not interested in taking a moral position regarding the play, nor interested in "cleaning up" the child's story or giving the child a particular solution to the story. The therapist is interested in why a child is having trouble finding a satisfactory solution. The therapist's job is to help the child structure the story and to expand the narrative, finding the right words to capture what the child is trying to convey.

The therapist's ability to play freely and enjoy play is an important aspect of engaging a child in pretend. Some child therapists are very wary or guilty about "just playing," as if it were not doing the serious work of therapy. Playing is often the best way to deepen the therapeutic engagement. Play can feel intimidating to the therapist, just as it can for the child, because of its open-endedness and because one uses the deepest recesses of one's own experience to participate. Therefore, the therapist has to feel confident in her capacity to contain the internal affective elements aroused in both herself and the child. Of course, there are always moments when the frame of pretend collapses under the weight of the affective struggle, at which point the therapist must move in, reinstitute the frame, and repair the disruption.

Play often stops when impulses break through. Letting the child know that there are ways to tell his story that are safe and won't make him feel too scared or too guilty is an important part of reestablishing the frame for the child. For instance, if a child wants to examine the therapist while playing the doctor game, it is helpful to move the play from the macroscopic sphere to the microscopic sphere.⁴⁰ I might say, "show me what you want to do to me on this doll; then you can pretend anything you want." Macroscopic play is likely to be more overstimulating than symbolic play with toys. Macroscopic play is also more limited in what can be permitted to be actualized. One can frequently help a child calm down and become more organized by moving to a more structured form of play.

Clinical example of disruption of real play

One day during an intensive psychotherapy with a very inhibited 6-year-old girl, Heather convinced me to play a game of tag with her in my office. Although I don't usually play tag because the space is small and the game itself involves tagging, a kind of touching, I agreed because of her insistent request, which I heard as a need to show me something. Quite soon after I began to chase her, she grabbed off her shirt in a frenzy of anxiety and excitement. I stopped the game, saying that this game had gotten her too excited. I added, nevertheless, that I really wanted her to find another way for her to tell me the story of the "clothes coming off." With a great deal of scaffolding on my part, she was then able to make some drawings of something she had witnessed that was very overstimulating and frightening to her.

Although this was a tag game and not imaginative play, I have considered this example as similar to a play disruption. Helping the child reestablish the play frame by putting her feelings in the form of a narrative story was helpful to her.

Play Enactments

Play can also be used to enact something with the therapist in a defensive way. It is not that the play does not have communicative value, but that the enactment carries the emotional valence.

Clinical example of play enactment

One patient of mine, a 9-year-old girl, played that she was the queen doll and I was the servant doll every time we met. She would dump out her doll's wardrobe and I would have to tidy up her clothes repeatedly. I had no voice in the play and had to say whatever the queen doll wanted to hear. When I did something that was more rebellious or assertive, I was made to suffer more humiliation or banished to the dungeon.

Certainly one could understand this play as communicating something about my patient's experience of feeling dominated in her family, and as an attempt to counteract this experience by turning the tables, an identification with the aggressor. Nevertheless, as this play enactment continued without change, it began to lose its metaphoric capacity. The sadomasochistic relationship was transferred to the therapeutic relationship, in the guise of play, whereby the nature of what was happening between us was not at all playful.

Therapeutic play at its best involves a situation in which both patient and therapist have a voice and are willing to acknowledge the other person's initiatives. I often talked through my servant doll about how she felt: sad, frustrated, enraged, and full of revenge. I also talked about the ways that my doll did not like being the "lowly servant" and was trying to find ways to elevate her sense of self and self-worth, but I could not find a way to be heard from within the play. Nor could the sadomasochistic impasse be addressed from outside the play because the patient denied that there was "really" anything demeaning going on at all; it was all "pretend." I saw this response from my patient as a further communication: a way she conveyed to me her sense that humiliating things went on in her family that no one could acknowledge or own.

I eventually had to extricate myself from this enactment by refusing to play unless we had different ground rules. Although this did not seem like an optimal solution at the time, it brought the patient's fury at me into the open and we were able to work productively on her envy and hate. It is important to recognize, however, that the many months of playing out the sadomasochistic enactment provided important experience that we had both lived through. This shared experience became a background and a reference point that enabled the work that followed.

HELPING CHILDREN TO PLAY

Winnicott⁴¹ wrote that when children cannot engage in play, it is the task of the therapist to help them to play. Often this is true for the very young child and for the child with an impediment in the capacity to play. The therapist must introduce play and scaffold it, just like the mother of the infant who introduces the peek-a-boo game (a pretend game about separation) and toys to her child as part of the child's development.

The initial engagement of the child patient is important, and engaging a child through play, without a lot of talk, is one of the most successful ways of beginning play therapy. Children are often delighted that the therapist has toys in the office, and children will often begin by playing out their most pressing affective themes. Nevertheless, the therapist often needs to invite the child into the play mode and give him permission to play. In *The Piggle*, Winnicott⁴² has a particularly engaging way of initiating play with a very young, inhibited child.⁶ Winnicott starts out in a corner of the room away from the child, makes friends by himself with a teddy bear, and asks the young patient to come and show the bear the toys.

I often start to play by telling a story or putting something that has actually happened between the patient and me into a puppet show for the child, using animal puppets with pretend voices. I might try to involve the child by asking what names to give the characters. I often inject something playful about the names of the characters to let the child know that we can depart from reality, revise it, or poke fun at it. I ask the child for input about what should happen next. I try to pick a theme that will be appealing to the child and, as time goes on, I add what the child cannot or will not do for himself. I scaffold the play, helping the child to structure and expand the play.

To shape my interventions I use my own imagination, but whatever I say is informed by everything I know about the child, both consciously and unconsciously: the child's history, family experience, the previous transactions between us, and the child's interests, favorite books, and favorite shows. I aim to stay in the neighborhood of something that will be of interest to the child. Obviously I try to start with less charged themes. This attempt to engage the child in play is a process of trial and error, and the therapist must take her cues from the child about what is working and what is met with negativity, what may be built on, and what is best to abandon for the moment. The play space is a joint imaginary arena that has to be negotiated between patient and therapist.

Equipping a Playroom

Therapists have their own individual preferences for what toys they have, but if the therapist wants to encourage imaginative play, the best toys to have on hand are nonmechanical, noncomputerized toys that can be used open-endedly for symbolic play. Dollhouse figures, dollhouse furniture, small animals, blocks, action figures, cars and trucks, Lego bricks, and plasticine food all lend themselves to creative play. The office should also be well stocked with markers, paper, tape, scissors, whiteboard, and Play-Doh so that drawing, writing stories, constructing, destructing, and repairing can all be easily accomplished.²⁸ Having said all of this, there are of course many creative and successful ways to introduce pretend play with different toys. It is also important to have a place where the child's projects and drawings can be kept safely in between sessions and out of sight of other patients, because attention to and care for the child's projects promotes a sense of continuity and conveys a sense of value about the therapeutic work. Symbolically this makes a space in the therapist's world (and mind) for the child and the "work" of therapy. I encourage patients to leave their projects in the office, but I never make it a rule. I often make a copy of a child's drawings or stories to keep in the office if the child wants to take them home.

HOW TO TALK TO PARENTS ABOUT PLAY

I believe the therapist must be actively engaged with parents to make the child's treatment work. Therefore I see parents separately, but regularly, whenever I see a child in treatment. Of course, the child is informed that I see the parents regularly. The goal of

this adjunctive parent treatment is to help parents to be better parents. I try to be flexible in working at whatever level the parents are able to work in order that this goal is best achieved. This flexibility includes being available to parents in a time of crisis, helping them understand why their children are having trouble, advocating for their child's needs with other psychological helpers and educators, talking to parents about development, and helping them understand the dynamics in the family. I also try to understand who parents are psychologically and to work with them on how their own conflicts get played out with the child, whenever we can work at that deeper level (**Box 3**).

Outside the playroom, I try to remember that the child is a very important member of a family system and is significantly affected by parents' perspectives and behavior, both positive and negative. In parent work, I try to intervene to improve the parent/child relationship. I do this while keeping the child's specific communications to me confidential, and the parents' specific feelings and concerns about their child confidential as well. Although there are complications and difficulties in this ability to relate to both parents and children, I believe this approach has the best chance for therapeutic success. I convey that I am a person who is there to help the family, not just the child. I convey that there is a need for me to keep confidentiality in my relationship with the child, and that this is a matter of how the relationship works best.

Some parents think that their children are supposed to talk in therapy, so I explain that therapy with children is very different from adult therapy. I inform parents that play is often the best way that a child can communicate to me, because children, especially young children, cannot talk about their feelings in the same ways that adults can. Although play is fun and compelling, it is not an avoidance of work; play is actually the work the child is supposed to be doing.

Early in the consultation I often give examples to parents of how I listen to play as a communication and how I use play to work on a problem. I may use an example from play the parent has witnessed with the child, or an example from a common clinical situation that does not breach the child's confidentiality. For example, I explain that if a child is inhibited and afraid to talk about anger, playing about being angry with a crocodile puppet is a helpful, liberating step. I try to describe what I have observed about the child and what meanings I give to these observations. I am also clear about what I do not yet know and what I will be trying to find out. I find that treating the parents as partners in the child's treatment is a helpful way to frame the relationship.

Box 3**Helping parents be better parents**

1. Be available to the parents in times of crisis
2. Help parents understand why their child is having difficulties
3. Advocate for the child's needs with other health care providers and educators
4. Talk to parents about child development
5. Help parents understand family dynamics
6. Seek to understand the parent psychologically
7. When possible help parents understand how their own issues get played out with the child
8. Maintain the goal of improving the parent/child relationship
9. Treat the parent as a partner

Preparing a Child for the First Visit

Preparing a child for the first visit is an important part of the process of engaging the child and the parents. My preference is to meet the parents alone initially to get a good understanding of their concerns about the child. It is also important for me to find out how the parents plan to prepare the child for his or her first meeting with me. By eliciting this information from the parents initially, the therapist will obtain a good sense of how the parent is conceptualizing the therapy, as well as what the parent feels is important to communicate or avoid communicating to the child. I usually suggest that things often work best if parents describe the therapist as a doctor or person who helps children with their worries by talking and playing with them. I also suggest that parents address directly why the child is coming to see me. It is always better to lead with something that the child will want assistance with, rather than a behavior the parent wants to extinguish or labels as “naughty.” For instance, it is better to say we are seeing the worry doctor because “you are unhappy at school” rather than because “you don’t listen to the teacher.”

THE THERAPEUTIC ACTION OF PLAY

Psychoanalytic investigators differ among themselves about what accounts for cure in psychoanalytic treatment and psychodynamic therapy. There is now a fascinating debate in adult psychoanalytic theory about the contribution of words and the nonverbal: the place of language in mental life and in therapeutic change.^{43–48} This debate has implications for treatment technique. Similarly, in work with children there is debate over what should be decoded from the play, put into words and interpreted directly to the child; what should be verbalized and left as part of the play dialogue, and what should be left unspoken altogether.^{8,9}

The increased interest in what is communicated implicitly and nonverbally in psychodynamic therapy is a result of increased data from the neurosciences, infant research, and cognitive psychology. We now know that much of what is transmitted in a room between two people goes on outside of their conscious awareness. We also know that therapeutic change can occur in conscious and nonconscious brain systems, and that these systems can enhance each other, rather than working in an either/or way.⁴⁹ Implicit or nonconscious change is possible during play not only because procedural relational systems (implicit relational knowing) can shift,⁴³ but because in a rich play process symbolic ideas can be “played with” metaphorically, just as they can in language, without necessarily being made explicit through interpretation.^{8,9} At the same time, narrative, an important part of the play process, helps organize internal affective states by lifting subsymbolic affective states partially into consciousness.⁵⁰

In the last 2 decades an increasing number of clinicians working with and writing about children have taken the position that helping the child to engage in the play process is just as important as verbalizing the meaning of the play content.^{5,8,9,16,17,30,36,51–56} Even when the play content is not explicitly decoded or interpreted, these investigators have been impressed that the play process is therapeutic in its own right and can bring about change. If we think of play as making contributions to development in natural settings, it is not difficult to imagine that helping a child to play in the clinical setting might have important benefits as well.

In development, imaginary play reaches its peak during early childhood (age 3–7 years) and is an important capacity that emerges in confluence with other significant developmental capacities such as the emergence of language, symbolic functioning, self-regulation, reality testing, triadic relating, and theory of mind. Developmental research shows correlations between these emergent capacities rather than causal

connections,² therefore it is not exactly clear what relationship these capacities have to each other, what the specific function of play is, or how play contributes to development. Nevertheless, there are several compelling hypotheses that have been generated in the psychoanalytic and developmental literature.

Pretending is introduced very early to the infant by the caregiver, and is understood even in its most elementary forms by the infant as something “not real” and something pleasurable; this occurs well before the infant can pretend back. One hypothesis about the function of pretend is that the caregiver organizes and regulates the infant’s emotional experience by a process of affect-mirroring whereby the caregiver plays back the infant’s emotional states to the infant through facial and vocal expressions that are “marked,” exaggerated, or “pretend,” not real.^{3,57}

Fonagy and colleagues³ hypothesize that, over time, the infant learns to decouple mental states from reality through the building up of second-order representations communicated by the caregiver’s marked responses. These investigators see this very early use of “pretend” as a way of establishing affect regulation and see it as a way the child learns to separate inside from outside, me from not me, and as an important forerunner of mentalization. Mentalization is the human being’s unique capacity to understand that there is not a single perspective of the world, but that meaning is personally created and is subjective.

Psychoanalytic investigators have written that playing, apart from its particular content, contributes to mastery,^{1,20} integration and repair of disturbing experience,²⁰ problem solving,¹⁹ regulation and integration of affect,⁵⁸ making experience meaningful and coherent,^{17,55,58} promoting reality testing and theory of mind,^{3,4} developing insightfulness,^{59,60} and enhancing the ability to achieve intimacy in relationships through communication and shared meaning.⁵⁸ A therapist is a highly skilled play partner. By scaffolding and expanding the child’s play, a therapist helps the child to hone a developmental tool that can be used to make sense of important affective themes in life, and that can be used to structure and organize future experience. Play in this sense is not so much about uncovering meaning as discovering meaning.⁵

Unlike reveries and daydreams, play is primarily social. Even when children play alone, as many 2-year-olds do, the play is often about social experiences or requires approval from the sidelines.⁵ At ages 5 to 7 years, imaginary play becomes an even more complex social activity that occurs with peers. Children negotiate how they will play together: they have to decide what stories and themes will be played out, who will pretend to be whom, and whose perspective will prevail. This process involves turn-taking, flexibility, an understanding that different people have different ideas, and the willingness to compromise in order to stay engaged and part of the game. Participating in this kind of social play is obviously related to the child’s capacity to mentalize and to participate in joint making of meaning. For children in whom these social capacities are impaired or lag behind, the play process enhances these developmental skills.³⁶

SUMMARY

Imaginary play is privileged as a clinical technique in working with children, because it is often the child’s best way of communicating affects, fantasies, and internal states as well as complex conceptions about the self and the world. Pretend play relies on a narrative structure and, like language, uses conceptual metaphor. It also uses nonsymbolic, action components that communicate meaning. Because imaginary play is pretend, children are freer to express their forbidden and conflicted thoughts

in play, removed from the constraints of reality and their conscience. Consequently, one of the best ways for the therapist to enter the child's world is to do so from within the displacement of the play process. Interpreting the unconscious meaning of the play material directly or attributing the feelings or wishes directly to the child may easily shut down the play process, as well as miss some of the nuance. Because play can be read on multiple levels, it is important to be open to the many different levels of meaning on which the play may be operating. We cannot assume a one-to-one correspondence between the child's play and what the child has actually experienced. Rather than finding one overarching meaning of a particular piece of play, it is often the ability of the therapist to help the child to continue to elaborate different meanings that is the most useful therapeutic technique.

There are many children who cannot play for a variety of clinical reasons, and it is the therapist's goal in these cases to teach the child, as far as possible, to use play as a means of self-expression and as a way to create meaning in the presence of another. Many investigators believe that just as play promotes growth in normal development, play in therapy enhances a child's capacities to relate, negotiate shared meaning, and regulate affect, quite apart from the particular symbolic content of the play itself.

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