THE VALUE OF PLAY THERAPY IN CHILD PSYCHIATRY

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Dr. Margaret Lowenfeld: To be successful a discussion upon anything must be based upon agreement as to the meaning of the terms to be discussed. It is worthwhile, therefore, to consider the meaning of the four words in the title.

The word PLAY is usually associated with children, but it has a very much richer meaning than that and is commonly used in four senses, all of which go to make up the content of Play Therapy rightly understood.

The word play as commonly used in English has four meanings: Play as the opposite of work; Play in association with "games"; Play as it is used in the theatre; and Play in connection with observation of natural objects, the play of light and shade, for example, and in connection with instruments, play the piano, the playing of an orchestra.

The essence of the first use is the doing of something for the enjoyment one gets out of it; of the second, the carrying out of a social activity whose essential characteristic is the obedience of all players to prearranged rules. In the third use, the word becomes for the first time serious, and is the presentation of someone not oneself, while the play played by the player presents the author's attitude to men and women, his view of right and wrong and his personal reaction to his personal experience.

The fourth use is curious, it is the use of a mechanical instrument, a piano or a violin to express experiences which cannot be rendered in any other medium, and in which, even if the subject matter be given, the "meaning" given to that subject matter is personal to the player. If we are to use this word correctly as a description of therapy, all four qualities should be included.

To pass to the word Child, in common speech this word occurs in reference to all ages from about 3 to school-leaving age. The words "infant and toddler" preceding it, and "adolescent" or "young person" succeeding it. On the other hand, when the word occurs in mental hospital statistics, it commonly connotes an age of 16 or 17, and many discussions on matters concerning the children come to grief through lack of preliminary agreement as to the age range which is being discussed.

PSYCHIATRY is a term which originated with adult medicine, and has only comparatively recently come to be applied to children. This is a dangerous process as few concepts, customary and valuable for purposes of description of adult phenomena, can be safely transferred as they stand to children and this is no exception.

The essential of the concept of adult psychiatry is that it is based upon a behaviour criterion. Applied to children this led, quite naturally, to the selection, apart from rare cases of unmistakable psychosis in individuals under 20, of children who failed to conform to the adult conception of correct behaviour, and child psychiatry originated with Healy and Bonner's work on delinquents. Leaving the defectives on one side as falling into a separate class, consideration of delinquent children came to be extended to those unable to show adequate educational progress, to behaviour difficulties within home and school and only in a small part to children with difficulties within themselves. But the scope of modern psychiatry is far wider than this, and includes the psychoneuroses, psychosomatic disorders, and the study of personal anomalies of development. Should not the same range be included in child psychiatry? The value of any form of therapy cannot be assessed adequately until we know to what cases it is proposed to be applied.

With the word THERAPY we come to the heart of our problem. What is the goal we are to set before ourselves in child psychiatry? We find ourselves in a curious position. Child psychiatry is in a pre-Kraepelin stage of development. Clinical description is the basis of medicine, whether that be psychological medicine or any other. Where are we to find the clinical descriptions and the systematized psychopathology upon which child psychiatry is to be based? Are we interested in the child himself, and in what study of the child can tell us of the nature of human beings and of the possibilities latent in man? or do we agree with a recent writer that "First and foremost come environment, the parent and the home, then the teacher and the school" Are we to set as our goal the adjustment of the child to his

environment, taking that environment as a given factor, or are we to aim at the development of the potentialities of the individual child? Until we have come to some agreement as to the goal of our work, we cannot estimate the value of any technique that we employ.

Associated with this problem is that of the individual who is to carry out the therapy. If we read carefully Mr. Alexander's Minutes of the Child Guidance Sub-Committee of the Association of Education Committees, we find that “diagnosis and treatment" of the whole range of difficulties occurring in children both at school and at home from the ages of 2 to 18 are to be carried out by “a fully qualified educational psychologist capable both of diagnosis and treatment.” When we look further to see what form of training is going to equip such an individual, we find that psychiatry does not appear at all. In Mr. Alexander's view, therefore, the difficulties of children arise in spheres other than those covered by child psychiatry.

Within the field of medicine, the views of those who practise child psychiatry range from those of Mrs. Klein and her group of pupils, who demand a very long and highly specialized form of training occupying many years, to those of a recent writer who described her training in the following terms: “Play is the language of children. They know it but we must either recollect it from our childhood memories or acquire it through analysis of ourselves and observation of the child. It is our patient who must help to re-educate us." In certain clinics the practice has grown up that if play is carried out as therapy it should be under the charge of a social worker, but in no case, so far as I have been able to discover, is this accompanied by any suggestion that the social worker should have a training in child psychology, child psychopathology or child psychotherapy.

We now come to the question of play therapy as a technique. There are four types of such therapy. First comes restitutive play. All children need room to run in, a secure atmosphere to play in, earth, air and water to experiment with and enjoy, and things to make and to do. Some children can accommodate themselves to what they get while others become ill through the deprivation of these opportunities which modern civilization makes inevitable. Restitution of such elements is a powerful therapy. To make this type of play effective, the right sort of building is necessary, appropriately equipped. With the right people in charge this kind of play can sometimes have a magic effect, but we need to be

clear that this is not the magic of psychiatry but of nutrition, the giving back to a starved child essential elements for growth.

The second type is play in groups with the objective of observation of the social behaviour of the children and to give assistance in their social adjustment. The greater the psychotherapeutic experience and understanding of the people in charge, the more likely it is that the group will be able to bring about in the children who take part in it lasting changes in behaviour. But, unless the group is in charge of someone with training and experience in child psychotherapy, this is not a psychiatric method, and non-technical play clubs can show parallel results.

The third type is the play therapy which deals with feeling and phantasy. Now the feelings and phantasies which underlie neurosis take place within the personality of a patient, and unless he can be induced to tell us about them and has the skill to make himself intelligible, we cannot help him. It is hard enough for adults to convey feelings in words and for children quite impossible. To attempt therefore to do direct psychotherapy with children, whose language is action, without knowledge of play and without opportunity for the child to express himself in play, is like attempting to treat an adult patient with whom we do not share a common language. It is this difficulty and the lack of adequate understanding of the structure of children's play, and particularly of the fourth form of play therapy, which brings about the confused transference phenomena with children which create so much of the difficulty in this form of treatment. The essential of play, used in this sense, is to put within the reach of children means by which they make clear to themselves and to us their inner experiences of feeling and phantasy: what use is made of the material produced depends upon the theoretical views and technical experience of the adults in charge of the work. The criteria of usefulness is the same in this, as in all forms of clinical medicine; that is, the suitability for treatment of the cases selected, the clarity with which the goal to be achieved is envisaged and the skill of the technician using it.

We now come to the fourth type of play therapy which is my particular contribution, and which I have decided to call direct projection therapy in order to distinguish it from other forms of play therapy, as both its basis and technique are different.

It has been my wish for a long time to achieve something more permanent in the nature of a record of the interior mental and emotional processes of children than the

fluidity of play permits. I want to be able to carry away from a play session permanent statements in concrete objects which can be stored for study, much as the preparations in a pathological museum can be stored, so that the personal element can be reduced to a minimum and the records studied scientifically apart from the child, thus enabling progressive comprehension of the phenomena and their objective comparison with each other. I have given fifteen years to this attempt and have succeeded in devising instruments which make this type of permanent objective record possible, and have available over 1,000 cases of children and young adults studied in this way by myself and the group that works with me.

A major aim of this technique is to minimize as far as possible the factor in treatment which is dependent upon the personal equation and the relationship to the adult worker. Each child goes through a regular routine which is clear and definite in the mind of the therapist, but widely flexible in regard to the child. It is also devised to give the child as quickly as possible a feeling of being in a new atmosphere and in a world of his own. For example, the child on arriving for his first visit is greeted by some member of the staff trained in child psychotherapy, and while particulars are being taken from the accompanying adult, is welcomed to a part of the building set aside for children, presented with the mosaic test and asked to make something he likes. It is then explained to the child that what he does in the playroom remains between him and the psychotherapeutic worker and will not be reported upon at home. From then on the child is encouraged to make use of as many of the technical, objective, recording methods as he is inclined to use. There are, for example, hexagon mosaics, kaleidoblocs, design units, on the one hand, and 'world' material, town planning material, etc., on the other, supplemented with verbal methods such as the newspaper game, sentences, etc.

A running commentary is kept up as the child works, making him aware of what he is doing as he does it; but the deeper significance is not interpreted to the child until it emerges unmistakably from his work. In this way what appears is a presentation in which an object, a thought about an object, the same object in quite a different light —perhaps inside out—the essential meaning of the object to the child, and perhaps a puzzle concerning the teacher's name for the object, can all be presented together. Other observers seeing this material are interested in what can be brought about through interpretation of the objects

in terms either of their affective meaning or their place in a pre-known theory of the mind. My interest is in the reason why exactly those objects appear at that time and place and arranged in that exact way.

The characteristic of this material is its difference from what one had expected. What is being dealt with in direct projective therapy is not primarily feeling, though feeling comes in later as a consequence of conceptions formed, but the processes of formation of early concepts, of these records of sensation, and the systematization of personal experience which each individual child makes for himself. In the U.S.A. Eric Homburger Erickson has been exploring the same region, and Margaret Mead in her recent anthropological study of the people of Bali bases her work on his findings. Schilder's and L'Hermitte's work on the body image is relevant to what appears, and much that other workers have done on thought-forms in schizophrenia. That is to say that study of a long series of this type of objective production has brought to light a region of human experience as yet uncharted and undescribed. A strange characteristic of it is that there is in it neither time nor space, sequence nor direct causality. What it appears to me we have found in this region is, as it were, the prodromal form, the first or primary form, of thought, and for this reason I have suggested it be called the primary system. As the infant and young child has no frame of reference outside himself, or tool with which his experience can be shared with and checked by the experience of other people, each child has to make his own system of grouping and storing experience, and this becomes the basis of his approach to life. If either his actual experience is usual or his senses no keener than those of his fellows, then he will sooner or later find words, poems, stories, games, which echo his interior experience, and enable him to pass through it and to make adequate contact with the external world, expressing himself in and through it. If, however, something goes wrong, if he becomes languid, ill, fails to take interest in his schoolwork, fails to want to grow up, odd in behaviour, withdrawn, aggressive, peculiar, then what is happening is that the conclusions he has come to in his interior world are so different from his external experience, so frightening in consequence, that he remains sunk in it and cannot emerge to make contact with outside life.

If, however, working with him we can bring to his aid the facts I have discovered about this part of the mind, with their help discovery can be made of the inter-relatedness on

other planes of the objects he presents. The grip upon his mind of these, as individual, “mad," unrelated, terrifying objects, relaxes, and energy begins to flow through this system to the outside world.

In attempting to describe this region shortly in words, I find myself in a position as difficult as would be that of a pathologist asked to describe actinomycosis without the aid of slides, preparations or drawings. Perhaps the essential aspect is the light this study throws upon psychosomatic conditions in children and upon the genesis of schizophrenia and psychopathic personalities.

In practice all four forms of therapy interweave with each other, and in the Institute of Child Psychology no child or group of children is treated by any one exclusively. It is for this reason that we ourselves feel that a minimum of three years' training, together with a year on the staff and a personal analysis, is necessary for those who would take up the play psychotherapy of children, but we feel that, with this background and correct equipment, play therapy and direct projective therapy form a flexible and delicate technique for the study and treatment of children suffering from the whole range of complaints covered by child psychiatry.

Dr. Alan Maberly: The time would seem opportune for making an attempt to define the nature of play therapy, its place in child psychiatry and the training and status of play therapists. I suggest that the term play therapy should be restricted to a form of individual treatment of children suffering from maladjustment or behaviour disorders involving neurotic disability. It is psychotherapy utilizing play as a principal means of treatment. This is not to say that play may not in other circumstances be constructive and even, in a sense, therapeutic, but it should not be termed play therapy unless the therapist takes an active and essential part.

Play enters into child psychiatric practice in many aspects, apart from its therapeutic purpose proper. For all small children, and some up to adolescence, actions speak more clearly than words, and the therapist must be familiar with every form of symbolism in play whether as a dramatized phantasy or in body language.

We may therefore consider the first function of play as a method of communication. It offers a means of quickly establishing a positive rapport with the child and at the same time opens up a productive path for further investigation. Few children can use words happily to

express their feelings, even with adults who are familiar to them, and with strangers, self-consciousness and artificiality are inevitable. Play is at once a defence against, and a retreat from, personal contact, which makes free expression possible if not easy.

Establishment of contact with the child is a first essential step in the therapeutic relationship, this first function of play may be regarded as a part of play therapy, but strictly speaking therapy begins when the therapist enters into the play, of set purpose or not. It is important to realize that the child will gradually incorporate an adult into its play, whether or not the latter intends this to be so. Complete passivity on the part of the observer makes no difference—it only makes it easier for the child to attribute to the adult whatever feelings, whether of approval or of blame, he may expect or desire. One might in this way be presumed to approve an action or attitude expressed in the play of which one has no understanding. To this extent a so-called play therapist, untrained and without insight, may achieve a good result by observing the golden rule of a well-intentioned masterly inactivity. But it is not possible to say that such a technique can never do harm, and the ignorant healing the sick is no less inappropriate than the blind leading the blind. The above example, however, illustrates what one may describe as the first of the three principal techniques of play therapy, free play on the part of the child in the presence of a play therapist who remains passive, but in positive relationship with him. Without a positive relationship by which the child senses a friendly and sympathetic understanding, nothing can be achieved at all. Secondly, the therapist can enter actively into the play situation, either by a dramatic impersonation, or by interference with the pieces in the game, changing relationships, introducing new figures or removing existing ones. Thirdly, the therapist may interpret the meaning of the play to the child so as to bring to consciousness purposes and conflicts that have remained hidden or subconscious. The interpretation may relate to the play as such, or to the child's relationship and behaviour to the therapist.

It is clear that these three methods are in no way mutually exclusive, and all three may be utilized in certain cases either consecutively or simultaneously.

Some therapists lay great stress on the type and variety of play material available, while others attempt a certain uniformity and standardization. I do not think it is possible to generalize, and different workers will develop methods that they themselves find most effective, but to deal with children of all ages and all grades of ability it is necessary to have

a wide range of material. Sand, water and clay are the three essentials. With these a child will create whatever it wishes. But figures of men, women, children and animals, that permit of the dramatization of the world in miniature, lend themselves admirably to the needs of the child and often simplify the therapist's task of interpretation. Pencils, charcoal, chalks and paints appeal to the majority of children and are most effective where the expanse of paper and the quantities of paints are both large. It is always an advantage if the child feels constrained neither by the atmosphere of the interview nor the limitations of the play materials, but this does not mean an uncontrolled and uninhibited display, whether destructive or not. Such an eventuality could only occur with an unskilled and inexperienced worker.

So far I have only considered play therapy of the individual child. Treatment of more than one child at a time by the therapist has been tried, with varying degrees of success. Unfortunately, it has often been regarded as an easy and harmless form of play therapy, open to the less experienced worker, whereas the converse is probably nearer the truth. In my view group therapy, with or without the aids of play material, or dramatic participation, is only effective in a residential establishment, whether hostel or school. The therapist must live with, and therefore be a living part of, the group. To avoid confusion, it is probably wiser mainly to restrict the use of the term play therapy to treatment of the individual child.

To recapitulate:

Play therapy is a form of psychotherapy in children utilizing play material as its principal instrument. It is carried out by a therapist having a defined and conscious purpose, namely cure of a disability. The term should be used in no other context.

The technique, and the form of play material, vary with different workers, but fall mainly into one of three types: (a) Passive association and observation; (b) active interference through the play material; (c) verbal interpretation of the play activity.

The play therapist treats the child and should therefore be, or work in connection with, a child psychiatrist. A lay play therapist forms a valuable, if not essential, addition to the usual Child Guidance team.

Play therapy, like all psychotherapy, is skilled work requiring exceptional personality endowment and prolonged training. The organization of a professional association of play therapists and the formulation and recognition of standards of training are much overdue.