The Therapeutic Action of Play

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Man only plays when in the full meaning of the word he is a man, and he is only completely a man when he plays.

—Friedrich Von Schiller on the Aesthetic Education of Man, "Fifteenth Letter" (1795)

Play in the therapeutic setting augments the child's innate capacity for synthesis and organization of affect. Play supports developmentally progressive and adaptive forces in children and adults. Facilitating play in the therapeutic setting involves encouraging each child to create his or her own play without redirecting or interrupting the play. I will explore the demands that facilitating play in therapy places on us as child psychiatrists. In addition, I will examine some of the complexities of our efforts to understand what the child's play communicates.

I want to emphasize that play in the therapeutic setting, even with a minimum of verbalization and interpretation, powerfully facilitates development. This point of view has been developed by Huizinga (1949), Axline (1947), Millar (1968), Piaget and Inhelder (1969), Winnicott (1971), and more recently Sanville (1991) among others. The therapeutic action of play itself is easily overlooked in the context of the vast array of therapeutic interventions available to the child psychiatrist today. What is perhaps new in my discussion is my belief that play is an innate capacity built into the structure of the brain. Play provides an opportunity for organization and synthesis on the part of the growing organism—the child and the adult. Evidence has accumulated that animals also use play to modulate aggression and promote bonding and affection (Brown, 1994). As part of development and survival, humans attempt to evolve increasingly complex but flexible systems of organization. Creative forces in play powerfully facilitate the emergence of new comprehensions. These comprehensions are most crucial in the affective realms and involve symbols other than words. Play provides these symbols in terms of the process of acting on materials, objects, sounds, space, and time.

Historically, attempts to understand the therapeutic action of play have focused on the treatment of neurotic symptoms and conflict. Ideas about the uses of play have included repetition and mastery of trauma, conflict, and affects by changing passive experiences into active ones. Play has been understood as part of a process of reworking past difficulties and painful experiences and as a guide to reconstructing the child's past. The child psychiatrist's traditional interventions have included development of the therapeutic alliance, providing a holding environment, analysis of defense, and clarification and interpretation of the transference. Although I am in agreement with these points of view, the therapeutic action of play itself is also an essential part of our intervention.

Play in itself allows the child to bring forward and explore feelings that are most troublesome and important. In this process the child expands an organizing aspect of the psyche and brings order to the chaos of preconscious and unconscious affect and experience as it is explored symbolically. This point of view reflects my controversial belief that affect can be experienced, organized, and communicated without conscious awareness or a reflective cognitive component. For example, an 11-year-old boy who had few friends and did poorly in school, despite being very bright, played versions of hockey games during his therapy hours. In these games the rules were unclear and changed unpredictably, so that I might come close to victory but would always lose. This had to be played out at length before I could talk about how frustrating, confusing, and depressing this was for me. It was my impression that he became aware of how guilty and confused he felt about his anger as much from just playing this out as from my eventual comments about my feelings during the games. As he began to recognize and master these feelings, his difficulties began to resolve.

Play is a vehicle for symbolism and metaphor which the mind in turn utilizes to provide a scaffolding for structuralization, integration, and organization of affectively charged experience. The play of the 11-year-old boy described above

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provided a metaphor he could use to organize his frustration and confusion in relation to what he experienced as inconsistent, unreasonable expectations. The assimilation of affects and experience, past and present, into an organizing aspect of the mind strengthens the ego. This process of play bringing coherence to affectively charged experiences does not detract from the therapeutic effect of play in relation to verbalized insight, reconstruction, and interpretation of the transference. Here I am distinguishing between play as a communication with the self and play as communication with the therapist. There are unique individual oscillations between these rather than the presence of one or the other. The balance and prominence of the therapeutic impact of these experiences depends on the individual child and the complex vicissitudes of the child's constitution, life experiences, development, and psychic structure.

Many child psychiatrists have experienced therapies where children have improved in a dramatic and enduring way although the play remained displaced and not related verbally and directly to the important people in the child's life. In these situations therapy has proceeded without insight being verbally or consciously structured. The child may make many drawings without discussing them, play structured board games with powerful themes that are not discussed directly in relation to the child's life, or remain silent and sometimes openly antagonistic to the child psychiatrist while occupying himself or herself with books or magazines. Perhaps these aspects of therapy are not emphasized because as child psychiatrists we fear that the interventions are not sophisticated or important enough to warrant the child's being brought to a child psychiatrist rather than to any good-hearted adult playmate.

It is difficult to maintain a position of constraint and permission for the child to elaborate his or her own work, to allow the play to expand, and thus encourage the child to continue and eventually to understand some of what is being communicated. For example, a 12-year-old girl who was extremely antagonistic at home and in school played a game of Olympics in which a young girl won many gold medals. She refused to discuss this in relation to her life. She had grown up in the shadow of a favored older brother. She indicated that I was to continue to admire this Olympian's prowess while she expressed great contempt for me, snarling, scowling, and not talking to me for hours at a time. This was so unpleasant it was difficult to allow the play to expand. During her therapy I felt what it was like to have someone idealized while I felt confused, useless, angry, and embarrassed. Although we did not discuss this, she came eagerly to her therapy hours and improved dramatically in her life.

As child psychiatrists we need to see both the defense and the communication in the child's play and to tolerate the powerful affects that emerge. Among others these affects include anger, sadness, helplessness, humiliation, worthlessness, sadism, sexuality, and dependence, and they raise taxing countertransference stresses. Difficulty tolerating these painful affects can lead to defensive efforts such as intellectualization, premature intervention, manipulation, limit setting, and other activities that bring closure to the child's explorations. Establishing and maintaining a therapeutic situation depends on the therapist's sitting with the child's painful affects and trying to help bear them. It is critical that the therapist not intervene to avoid these affects. Central qualities of the therapeutic situation are an accepting, noncoercive environment dedicated to an empathic appreciation of the child's internal experience. At the same time the therapist needs to establish and maintain a reliable and safe setting and respond to events that diverge from play. Such events include those having reality consequences such as acts that would endanger the therapist or the child or do damage to the office or the time constraints, such as refusing to leave at the end of an hour. Fortunately, our child patients are quite forgiving of our struggles, our inattentiveness, our insensitivity, and our inexact interpretations or interpretations based on our need to understand, to feel valued, or not to feel helpless.

Play in the therapeutic situation provides a new stage on which the child can attempt to find organization for affectively powerful aspects of his or her experience and inner life. The therapist accepts role assignments and is the empathic interactor in the play and dramas. The therapist's situation as someone who accepts without attempting to deflect the affect, who experiences the play as a revelation, and who appreciates the exploratory aspect of the effort supports what is a preexisting faculty for dealing with conflict, trauma, and powerful affect using the vehicle of play. A 10-year-old boy whose mother died of breast cancer when he was 3 years old was caught in a deeply ingrained passive-aggressive, self-defeating pattern at home and with friends. Over many hours he used the board game, Clue®, to elaborate a drama in which Miss Scarlet, a double agent, ruthlessly murdered her friends and finally was caught and tortured by being injected with poison that "stung like the bites of a thousand wasps." This play seemed to reflect some of his experience of his mother's illness, her chemotherapy and death, and his confusion, guilt, and identification with her.

The innate capacity of play for organization, synthesis, and promoting self-regulatory processes provides a powerful therapeutic element. Perhaps all play is integrative. When we view play as endless repetition and symbolization without any movement toward growth or mastery, we often have not yet been able to understand or tolerate the struggle or communication involved. In addition, the increasing

awareness of the activity and process of the play helps to facilitate a self-regulatory process. As the child recognizes the symbolic dialogue in the play and changes it, there is the development of a meta-dialogue. A 7-year-old boy whose life had been restricted by a fearful and obsessional character decompensated after a sports injury in which he sustained a severe ankle fracture. Based on the board game, Life®, he developed new playing boards that helped him master issues such as ways to acceptably extract revenge, ways to construct flexible, reliable rules, how to decide what personality traits are most desirable, and how to be sure to have enough supplies in life.

For the creative possibilities of play to be facilitated, I find that it is best for me to reach for a freedom and openness in myself. For example, a 6-year-old girl with encopresis was doing well in all aspects of her life and her encopresis had resolved. Discussion with her parents led to my being convinced that it was time to stop and asking her whether she was ready to end her therapy. She adamantly said no. In the next 6 months she played at our constructing a baby together. The play and related discussions added important elements that we had not fully explored previously. Then she said she there was a boy in her class at school who she thought needed to see me and it was time for her to stop.

Sometimes there is a ritualized or repetitive quality to the play. Although this impedes a freedom and fluidity that are valuable aspects of creative play, stylized play also communicates the nature of anxieties, conflicts, and painful affects which, as they are elaborated and understood, allow the play to develop additional freedom and richness. For example, after about a year of treatment a very aggressive, oppositional 6-year-old boy, hour after hour, wanted me to supply large amounts of paper for him to cut up. I was struggling with my anxiety about his destructiveness and how much paper he was consuming. I said he seemed to be ordering me to bring more paper every hour. He replied, "It is not so bad, Dr. Ablon, you can do it." I took his advice and gradually the play evolved into the creation of enormously destructive paper creatures who had great appetites and consumed everything "even moons, suns/sons, and mothers." The creative potential of play provides resources for children and indeed all of us to maintain affective vigor and progressive development.

The central premise of this presentation is that play in the therapeutic setting powerfully facilitates developmentally progressive and adaptive forces, even with a minimum of verbalization and interpretation. This is possible because play is part of an innate capacity of humans and indeed other mammals to organize affects such as aggression, anxiety, and affection. For the purposes of survival there is an ongoing effort to develop increasingly complex organization of external and internal experiences and affects. Play is an especially effective vehicle for symbolism and metaphor which the mind utilizes to create a kind of scaffolding for integration and organization. Finally, I have tried to describe some aspects of the therapeutic setting and the role of the therapist in maximizing the adaptive power of play.

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