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Non-Directive Play Therapy as a Means of Recreating Optimal Infant Socialization Patterns

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The paper proposes that non-directive play therapy recreates conditions similar to those created between a carer and infant during normal development. By the heightening in therapy of essentially normal developmental processes the child with harmful or inadequate relationship experiences is enabled to rework and reintegrate these into normal interactive patterns. Ways are reviewed in which non-directive play therapy exemplifies important attachment properties in an individual's primary relationships, and recreates healthy carer–infant patterns of interaction such as topic-sharing, face-to-face interactions, mutuality and symbolic play, in order to bring about therapeutic change. This primary corrective function is similar to other responsive therapeutic approaches, but it is argued that a particular strength of non-directive play therapy lies in its inherent flexibility and responsiveness to the individual child, which resembles normal infant socialization with a sensitive carer.

Key words: Play therapy, infant socialization, attachment, non-directive.

We have recently (Wilson *et al.*, 1992) reexamined the merits of non-directive play therapy in therapeutic work with children and adolescents. While acknowledging previous difficulties in this method, largely arising from its atheoretical stance and from the misuse of therapeutic limits by some practitioners (see Wilson *et al.*, 1992, Chapter 1), we have attempted to correct these problems and to demonstrate that non-directive play therapy can be both a robust and effective intervention for troubled children. We have developed a theoretical basis for the effectiveness of non-directive play therapy using developmental principles and have delineated essential non-directive practice skills.

The uses of non-directive play therapy in court settings (Ryan and Wilson, 1993) and in family work (Wilson and Ryan, 1994) have also been more fully specified. However, outstanding issues include first, the ways in which other therapeutic approaches and techniques can appropriately be incorporated into the non-directive approach; second, the processes within non-directive play therapy which influence significant therapeutic change; and third, the method's longer-term effectiveness. The latter two issues will be addressed in a planned process and outcome research programme (Ryan, in press).

In this paper we shall focus more closely on infant development research, examining essential ways in which non-directive play therapy artificially

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creates conditions similar to the optimum socialization processes of an infant and carer during normal development. We shall argue that it is because of the heightening of essentially normal developmental processes that non-directive play therapy enables children with damaging social experiences to rework their interpersonal interactions into emotionally more normal socialization patterns.

Although this paper focuses on non-directive play therapy, the process of reworking interpersonal interactions is not unique to this approach; therapy in general is often viewed as a method of creating highly personal relationship experiences between a therapist and an individual. Bacal and Newman (1990) have highlighted the similarities between different therapeutic approaches, arguing that the concepts of containment, empathetic attunement and optimal responsiveness are all viewed as having primary corrective function within a therapeutic relationship. These intense experiences are used as correctives to the individual's primary relationships which have become distorted during development (Allen, 1942; Moustakas, 1959; Zeanah *et al.*, 1990).

Increasingly, models of child psychotherapy have adopted a developmental approach, with pathology being viewed as deviations from normal development and increased understanding of abnormal development being furthered primarily 'by charting normal developmental trajectories' (Cicchetti and Toth, 1992). This developmental approach to prevention and intervention is seen in programmes such as the STEEP programme for mothers and infants (Erickson, *et al.*, 1992) and Lieberman's work with mothers and toddlers (Lieberman, 1992). These have the intent of changing the carer's inaction with her child as well as the carer's internal working model of primary relationships and interaction patterns. Through this means the child will, it is assumed, develop a relationship with the carer which has normal attachment properties.

Other intervention programmes based on an attachment model use specifically non-directive therapeutic principles (Guerney, 1984; Muir, 1992). All of these programmes share the assumption that the therapeutic relationship and the individual's primary relationships have important attachment properties in common (Bowlby, 1977; Peterfreund, 1983). These shared properties include 'emotional availability, dependability, empathetic attunement, sensitivity to developmental needs and provision of comfort and security' (Zeanah *et al.*, 1990, p. 25). Treatment in the preschool and school years, as well as working with attachment figures, also often involves intervening directly with the child (Crittenden, 1992a; Buchsbaum *et al.*, 1992).

In this paper, non-directive play therapy is discussed as an intervention in which the therapist intervenes with a child to heighten normal developmental processes. In the following section we examine several ways in which non-directive play therapy exemplifies these attachment properties as well as the other basic developmental principles of exploration and competence. The second section highlights specific features of carer–infant communications: topic-sharing; face-to-face interactions; vocalizations; the development of mutuality and symbolic play. Next, we discuss the similarity of these features to patterns of child–therapist communications in non-directive play therapy, demonstrating therapeutic changes that occur in these interaction patterns. In the final section, we suggest that one of the particular strengths of non-directive play therapy, like normal infant socialization with a sensitive carer, lies in its inherent flexibility and responsiveness to the child. That is, because of its non-directive nature, this method offers the potential for highly individualized treatment of a child.

NON-DIRECTIVE PLAY THERAPY AND NORMAL DEVELOPMENTAL PROCESSES

The Non-Directive Method of Play Therapy

A unifying concept in this method of play therapy is its 'non-directive' nature: that is, the choice of content, issues and actions in the playroom is determined by the child himself, within certain basic certain limits set by the therapist. (For convenience of usage in this paper we adopt the convention of 'she' for the therapist and 'he' for the child.) Unlike other play interventions based upon the therapist's suggestions, interpretations and directions, the non-directive method assumes that the child himself is able to arrive at therapeutic insights and instigate therapeutic changes for himself under the optimum therapeutic conditions provided.

Although the contents of the sessions are determined by the child, non-directive play therapy is in fundamental ways also a highly structured intervention on the part of the therapist: a limited time is offered; the focus of the sessions is on feelings and emotions; largely symbolic play materials are chosen; and the play materials, the setting and the time of the sessions remain the same

each week. The therapy is carefully planned and organized, for example by ensuring that the carer (or another significant adult) brings the child to each session and, in addition, that the room itself is private, safe and free from interruptions. (See Wilson *et al.*, 1992, Chapter 3, for a more extended discussion.)

Security

The rationale for the above therapetuic requirements is based first of all upon the child's attachment needs. To enable the child to feel as secure as possible in a strange environment, the therapist deliberately attempts to create a familiar, safe environment which is immediately recognizable as such for the child entering the playroom. The familiar atmosphere tries to mimic the stable atmosphere of a normal child's home environment. The play materials, setting, furnishing and time remain the same each week and are thus predictable for even very young children, furthering their sense of security. Within this stable environment it is the child's own activities, thoughts and feelings, as well as the interactions between the child and the therapist, which are the dynamic, changing features. The child's external and internal activities and the child–therapist interactions will necessarily, then, be enhanced and intensified against this static background. The effectiveness of this structuring is evident in practice: it is common for children to want to personalize the room after a few play sessions, wanting to put their own drawings on the walls or to shift equipment around the room. At times some children even comment that they wish the playroom were their bedroom, expressing their strong feelings of relaxation, belonging and intimacy while in the playroom.

These familiar, secure environmental features are paralleled by the therapist herself. By adopting the same non-directive and non-intrusive, yet friendly and attentive attitude during each session, the child is able more readily to relax with the therapist, an unfamiliar adult, and to feel more secure in her presence. The therapist's responses correspond to a carer's interactions with securely attached infants: when a mother responds to her child promptly, appropriately and predictably, the child will build up a set of expectations about her from which he can derive security (Schaffer, 1989). The therapist, like the carer, conveys to the child by her generalized attitude each session that she is both emotionally available to him and highly dependable. This generalized attitude is communicated by the therapist to the child through 'emotive messages' in which the feelings, thoughts and wishes she has about the child's behaviour are communicated to him using both verbal language and non-verbal means, including her tone of voice, gestures and facial expressions (Heard and Lake, 1986). In addition, a child therapist must also accompany her emotive messages with compatible motor actions (such as actively retrieving a lost ball after the child has looked on helplessly).

The therapist's emotive messages and actions must be highly predictable for a troubled child because of his previous experience of less appropriate and/or less predictable support from his carer(s). The therapist achieves this high level of emotional dependability within sessions through the development of the personal characteristics described above and the combination of these with the practice of non-directive play therapy as a systematic and coherent approach. (Guerney, 1984; Ryan, in press.) Training in the development of personal characteristics and in the systematic use of the method itself, then, is essential to the development of the therapist's emotional predictability for a child.

At the beginning of therapy, sessions are unknown and potentially worrying experiences for a child. Before a child becomes confident with the therapist's and the room's predictability, it is important to ensure that the carer views the room and remains in a nearby room to provide the child with an immediate secure base derived from his or her presence. But this security may also be necessary and should remain an option at later stages in therapy, even for older children, because the child usually chooses to address emotionally more difficult personal issues as therapy progresses.

Exploration

Attachment research has found that secure infants are more able to explore new environments when in the presence of an attachment figure (Bretherton and Waters, 1985). Non-directive play therapy attempts to heighten the child's interest in exploring the playroom by creating a secure environment based on a familiar setting, the therapist's emotional availability and dependability and the presence nearby of a significant adult. The child's desire to explore is also increased by designing the room to maximize the symbolic, flexible features of play materials as well as suggesting their interesting possibilities (such as, say, a sand box *inside* a

building or clay that is freely available to use). The materials themselves tend to reduce the child's fearfulness, foster his curiosity and suggest a playful, non-threatening orientation towards his ongoing feelings, thoughts and actions. Play itself is understood even by a very young child as 'not "for real" [and it therefore] offers the child an opportunity to *try out real emotions in a protected context*' (Newson and Newson, 1979, p. 106).

Indeed, troubled children usually need a playful atmosphere even more than normal children because this playfulness is one of the essential interactions with carers which they have usually missed out on (Tinbergen and Tinbergen, 1983; Crittenden, 1992b). Instead, they have often had difficult relationships with carers and perhaps played primarily only with other children or by themselves rather than with or alongside interested adults. The therapist, by contrast, conveys to the child in their sessions through emotive messages and actions that his play and his presence is of central importance in their time together. She demonstrates to the child, then, that he is of personal importance to her, in a manner similar to that of a sensitive carer with her infant.

Unlike securely attached infants, however, troubled children initially may have difficulty including the therapist in their play, as we discuss further below. For this reason (illustrated in our discussion of infant–carer interactions below) the therapist must respond quickly and appropriately to even a slightly playful overture initiated by the child, conveying by her manner that she is ready to enter into the playful spirit at the child's discretion (Newson, 1993). In this way, a child is enabled to relax physically and emotionally in a safe, familiar environment and to use play to explore his emotional problems.

Competence

A child normally develops a sense of personal competence by continually learning that he is able to influence both significant people and objects in his environment by his behaviour (Schaffer, 1989). Exploration and competence are interrelated, as Heard and Lake demonstrate in their discussion of the two goals of companionable interaction and of supportive interaction in attachment relationships. They state that the functions of companionable interactions are to provide 'both shared awareness and understanding of an interest, and the recognition of competence; such interactions are therefore episodes in an exploratory endeavour' (1986, p. 431). A 2-year-old, then, develops a sense of competence by 'seeking help when needed and at times rebuking unnecessary interference by adults' (Zeanah *et al.*, 1990, p. 12). Non-directive play therapy, because of the therapist's non-directive stance, significantly enhances troubled children's sense of personal effectiveness and confidence as well as their exploratory play. Since the therapist is completely at the child's disposal, ready to respond physically and verbally to whatever action, thoughts and feelings he expresses, the child is able to make genuine choices within his sessions. He thus develops an ability to function competently in social interactions with a significant adult, as well as achieving greater competence and initiative in self-chosen activities.

INFANT–CARER COMMUNICATION PATTERNS

We turn now to specific infant–carer communication patterns and their relationship to non-directive play therapy. Briefly, the development of social competence in infancy progresses from several simpler skills which are then incorporated into more complex social routines. Following Schaffer (1984, 1989):

(a) During early development (up to 5 months approximately), infants concentrate their attention on their carers, with direct face-to-face encounters and vocalizations as the main force for social interactions.
(b) When the infant's manipulative skills increase (from about 5 months onwards), the infant's attention shifts from people alone to objects as well. Infant interactions centre on either objects or people, separately.
(c) Infants begin to coordinate their separate skills with objects and people (from approximately 8 months). They now become able to maintain social interactions with people while incorporating objects and external events into these interactions themselves.
(d) From 18 months approximately, the infant develops the capacity for symbolic representation; his social interactions with people become more complex and include not only object and events, but language and self-awareness as well.

At every transition point delineated above, as at all transition points in later development, the carer's

role is to help the child integrate new responsiveness to people and objects into more advanced social interactions. Both the carer and the infant must change their interpersonal sychronization as a result of the infant's increased responsiveness.

Troubled children are maturationally well beyond infancy (in fact, 2.5–3 years is the earliest age at which we recommend non-directive play therapy) and will not necessarily exhibit in therapy the sequential progression in social interactive skills outlined above. But it is these basic skills, as we shall discuss below, that are reworked and reintegrated into more normal interactive patterns as therapy progresses.

Face-to-Face Communications

The earliest social actions between an infant and an adult are mainly concerned with the regulation of mutual attention and responsiveness and are primarily developed within close face-to-face encounters. Unlike adult pairs, where gazing is mostly symmetrical, mother–infant gazing patterns are usually asymmetrical. The mother typically holds her gaze on the infant for relatively lengthy periods of time, ready to respond to any attentiveness from the infant. 'The mother, that is, appears to be almost constantly ready for interaction, but it is up to the infant as to whether that interaction in fact takes place' (Schaffer, 1989, p. 12).

Non-directive play therapy, as we have already noted in our discussion of attachment, is structured to maximize face-to-face interactions between the therapist and the child by ensuring private, one-to-one communications. Because of its non-directive nature, this method is also designed so that interaction between the child and the therapist can be asymmetrical, if this is needed by the child. With later therapeutic progress, the interaction easily can become more highly symmetrical. Similarly to mother–infant pairs, the therapist regulates her responses to suit the child, while the child chooses his own activities without pressure to interact with the adult, yet with the adult readily available for social interaction. But because of troubled children's earlier faulty social interactions and during the early sessions because of mutual unfamiliarity, the therapist must adjust even more sensitively than a carer to the child's interactions. (see, Stern, 1985, for interesting examples of non-synchronous, maladaptive mother–infant socializing patterns.) Instead of automatically looking at the child for long periods, it is vital that the therapist respond to cues from the child, say the child turning his face away, on the degree of face-to face interaction he is able to tolerate. Some very fearful children may find any face-to-face communication overly intrusive, while other children almost immediately scrutinize the therapist's face closely, but avoid direct eye contact (see Wilson *et al.*, 1992, Chapter 4, for an example).

One 10-year-old girl, Diane, for example, made up her face thickly with luminescent face paints during her first play therapy session and after struggling to remove them herself accepted the therapist's offer of assistance. As the therapist carefully wiped Diane's face, looking closely at it, Diane studied the reflection of the therapist's face in the mirror beside them. The therapist avoided Diane's gaze in the mirror and reflected quietly that Diane and she were getting to know one another better by working closely together. (This case is referred to in Ryan and Wilson, 1994. The name is kept the same.)

Newson and Newson remark that the human face is the infant's first 'toy' because along with interesting facial movements go 'linked patterns of interesting sounds . . ., which are geared to the baby's own rhythms . . .' (1979, p. 32). In normal development the infant early on recognizes that other people have 'the very special quality of being responsive to his own actions on a moment-by-moment basis . . . Babies seem to be particularly alert to forms of stimulation which are responsive in the sense that the baby can attempt to bring them under his own mastery or control' (1979, p. 30).

As we discussed above, infant development research has repeatedly confirmed that an infant begins to develop a sense of competence and mastery based upon a varied, responsive environment (Donaldson, 1992; Stern, 1985). In addition, under normal conditions, the child's understanding of his own actions is 'as it were, ... rewritten by his adult companions to make them more consistent and more significant to him than they could have been if they had not been expressed in the presence of a responsible care-giving person' (Newson and Newson, 1979, p. 34). Infants, then, seem to have an innate predisposition towards engaging in personally meaningful social interactions (Murray, 1989). In therapy with troubled children this predisposition can be (re)activated. The therapeutic process continually enables the child to realize that an adult can be highly responsive to his actions in a way that perhaps he has not experienced previously or has often experienced in a distorted way.

The Development of Infant–Object–Carer Interactions

A turning point for an infant normally occurs when his manipulative skills increase and he becomes interested in objects, but is not yet able to attend to objects and people simultaneously. The carer helps the infant, tacitly recognizing his limited attention, and the adult is the one to incorporate external objects into interactions with the infant. Bruner (1983) describes a variety of procedures carers use to convert infant–carer and infant–object situations into infant–object–carer interactions. Schaffer also notes this phenomenon, describing a research study of infants and mothers who were introduced to a playroom with an entire wall displaying various toys. There was a strong tendency for both the infant and the mother to look at each toy at the same time.

> . . . 'almost invariably it was the infant that took the lead by spontaneously looking from one toy to another while the mother, closely monitoring the baby's gaze direction, immediately followed and looked at the same toy.' (Schaffer, 1989, p. 14)

In non-directive play therapy children beginning play therapy often have a similar narrow focus: some children seem to keep their entire attention on the toys themselves, without being able to incorporate the therapist into their play, reminiscent of the infant–object interaction patterns described above; a few children, on the other hand, seem to have their entire focus on the therapist, without being able to incorporate toys into their play. One preschool child, for instance, seemed not to have progressed beyond face-to-face communication and used the therapist as a climbing frame during sessions (with the therapist becoming somewhat overwhelmed by this excessive physicality). Another 8-year-old child spent his early sessions using the play therapist as a horse, failing to display any interest in other objects in the room. The therapist's role in these contexts is to reflect the child's feelings, follow his lead and set safe (within what the therapist finds humanly possible) limits to his behaviour, waiting for the child to show beginning signs of interest either in external objects or in herself. She then helps the child, following his lead, to incorporate either of these actions into a more normal, age appropriate child–object–carer interaction pattern.

A particularly difficult instance is when a child directs sexualized responses towards the therapist. These feelings are inherently highly individualized. For example, the child's sexualized behaviour may demonstrate his predominant need for affection, an inability to distinguish between sexual and non-sexual ways of expressing affection and/or a wish to reenact an abusive sexual experience. The therapist's task is to set clearly appropriate child–adult boundaries, as well as to acknowledge and reflect the child's ongoing feelings. In this way, the child is enabled to choose appropriate means to rework his responses symbolically into healthier interactions. The therapist, then, responds sensitively and appropriately to the child's developmental needs, thus helping the child to expand less complex responses and alter distorted responses into more adaptable patterns.

Vocal Interactions

Turning to the early role of language in infant socialization, vocal interactions between an infant and carer are an integral part or their social interactions. Although speech has a biological basis (Pettito, 1992; Pettito and Marentette, 1991), interactions between a carer and infant are essential for normal language development. Adults use speech when interacting with infants from the neonatal period onwards and vocalization accompanies the child–object–carer interactions outlined above in regular ways (Bruner, 1983; Murray 1989). As with gazing, vocal interactions are also initially more asymmetrical, with the mother allowing herself to be paced by the infant.

In non-directive play therapy the primary use of language by the therapist is in reference to the child's own actions, feelings and verbalizations. An essential practice skill is the therapist's reflection to the child, using verbal as well as non-verbal means, of her understanding of what the child is experiencing internally and externally. By helping the child to create meaning and coherence in his self-experience, the therapist assists the child to master his feelings. Similarly to other responsive therapies which are based on theories of object relations and self-psychology, it is assumed that the therapeutic experience will lead to both an expanded awareness of the self and structural growth (Bacal and Newman, 1990). This process of accurate reflection in non-directive play therapy does differ, however, from a psychoanalytically oriented responsive approach. Reflection of feelings 'is, in a strict sense non-interpretive in that it remains in the present, uses on the whole the material that the client has used and avoids what has been described as the "now and then" kind of

interpretation, that is, one that links current material to past events. Thus Axline defines reflection as the "mirroring of feeling and affect"; as such it is communicated by the therapist within the metaphor used by the client (unlike, for example, in psychoanalysis, where what the client says or does may be interpreted and the metaphor transposed into what it appears, to the therapist, to be representing). In working with adult clients the "content" is likely to be verbal; with children the metaphor is frequently, although not necessarily, play' (Wilson *et al.*, 1992, p. 23).

In both non-directive and other responsive therapies, the therapist's function is 'similar to that provided by the mother when she "names" experience and thus meets the child's innate need and striving for organization' (Bacal and Newman, 1990, p. 256). Even more than normal interactions between infants and carers, however, the therapist must be highly sensitive to the amount of verbalization the child can tolerate from her. She must ensure, especially during initial or highly emotive sessions, that her speech does not become intrusive and inhibiting. By using her language to reflect the child's ongoing interests, the therapist is paralleling the normal language acquisition process:

> 'What the adult says should be related to the child's interests, attentional focus and actions at that moment. The mother therefore needs to be attuned to the child and tie her own comments with the child's concerns as well as with its abilities to process what she says . . . Under such circumstances language development proceeds more quickly.' (Schafer, 1989, pp. 25–6)

The Development of Reciprocity and Symbolic Play

As infants develop the capacity to coordinate more than one activity for themselves, they are no longer completely dependent upon the carer to integrate diverse activities. Social interactions between an infant and carer become more reciprocal; give-and-take games are developed, originally by the carer, and are gradually established as familiar, routine games. The infant learns that in play 'giver' and 'taker' roles are reciprocal and reversible (Schaffer, 1989). Playful social exchanges become the foundation on which infants develop rudimentary symbolic play. Newson and Newson describe vividly the beginnings of symbolization with Andrew, 12 months, who has developed, with his mother's help, a familiar play routine in which he offers his mother a pretend bite of his proffered (soggy) rusk.

> 'One day Andrew happens to be playing with a plate and a small wooden brick which is vaguely the same shape as the rusk. His mother notices this and says "Is that your biscuit?" simultaneously going into her well-understood "give me a bite" routine: that is, she is inviting him to offer it to her *as if* it were a rusk. Andrew responds to this with the appropriate offering gesture, but at the same time it is clear from his amused expression that he appreciates that this is just a joke; he already knows from experience that one cannot really enjoy eating a piece of wood.' (Newson and Newson, 1979, pp. 100–101)

This reciprocal exchange between mother and infant is comparable to the following exchange within non-directive play therapy, but with the difference that the child rather than the adult is in control of the way in which his activity becomes symbolic play.

> Patrick, a neglected and multiply abused 4-year-old, has been attending play therapy sessions for 2 weeks. His play during these sessions has been very concrete and circumscribed. Today he seems to suddenly discover the baby's bottle, which is alongside the feeder cup and mug on the childsize sink in the playroom. Patrick has the therapist help him unscrew the bottle, then he asks her if she wants a drink, saying he is too big.
>
> T: I don't mind. If you want me to.
>
> Patrick has the therapist screw the top back on after he fills the bottle with orange drink by himself.
>
> P: You drink it.
>
> T: All right. Maybe I'm a baby?
>
> P: Yeah.
>
> T: Waah! Where's my bottle?
>
> P smiles slightly and gives the therapist the bottle to drink. She drinks it, making satisfied noises (Mmmmm) while she drinks. P watches very intently, but without any sign of enjoyment at the therapist's pretend play. The therapist finishes sucking the bottle after a short time.
>
> T: (smiling) It's very odd to see a big lady drinking a bottle.
>
> She drinks a bit more while P stares intently.
>
> P: Want some more?
>
> T: I can. I don't really drink out of a bottle, do I? I'm just playing I'm drinking out of a bottle now.
>
> Patrick then starts pretending, although very unsurely, that he is taking the carer's role, telling the therapist to wait while he refills the bottle, managing to unscrew and screw it again himself. He gives the therapist a lot more to drink.
>
> P: Drink it.
>
> T: (smiling) You're taking care of me, giving me lots of drinks.
>
> The therapist drinks, then pauses to laugh while briefly glancing directly at Patrick. Patrick smiles slightly.

Like Andrew's mother, the therapist helped Patrick pretend that the therapist was a baby. Patrick adopted the reciprocal role of the carer, but with great hesitation and uncertainty. The therapist may infer from this play sequence that one of the important areas of experience Patrick seemed to miss out on in his earlier development was playful imaginative experiences with his carers (Ryan and Wilson, 1993). The therapist, like Andrew's mother, needed to support and encourage Patrick's initial attempts at taking a symbolic role with her. Unlike Andrew's mother, the therapist does not have shared rituals and routines with Patrick to base her pretend play on. Instead, based on her knowledge of child development and on the child's background, she must anticipate and enter into patterns of social interactions which are part of the child's experiences outside the therapist's new relationship with him. The Newsons state that Andrew will soon begin to enlarge his understanding of symbolic play in other, more self-initiated ways. The therapist anticipates that Patrick will also enlarge his tentative attempts at reciprocal roles at a later stage in therapy, perhaps placing the therapist in the role of a certain kind of child, say a 'greedy' child who always wants more in her bottle, while he himself plays the role of the 'angry' mother. Or perhaps a doll rather than the therapist will become the baby, needing all of Patrick's attention.

Another boy, Philip, age 5, was taken into care at 4 years of age, after prolonged concern on the part of Social Services at the severe neglect and physical injuries he experienced at home. His play therapy sessions demonstrate the development of reciprocal interactions, with the therapist in the role of a greedy child:

In his second hourly session the (female) therapist and Philip were engaged in a tea party game at Philip's instigation. Philip filled both tea-cups to the brim.

P: Shall I drink it or you? (referring to the therapist's cup, after drinking his own)

T: I think you would like to drink it, wouldn't you?

Philip then decided to let the therapist drink from her overbrimming cup.

P: Be careful!

T: I'll try to be. Very full.

P: Good boy!

After the therapist had created a permissive atmosphere and reflected Philip's feeling accurately in a non-threatening manner, Philip was able in this interaction to begin to put the therapist into the role of the child who wants to drink lots of drink and himself into the role of the adult in authority.

By his fourth session, Philip was using the baby bottle in his play. While Philip sucked from the bottle, the therapist reflected his feelings.

T: Now you are being a baby and sucking from the bottle. You want lots and lots and are sucking very hard.

P: You drink it (handing the bottle to the therapist).

P: That's enough! (as the therapist begins drinking)

T: You don't want me to have very much.

In this way, Philip reworked earlier experiences of deprivation and current feelings of unrelenting need (or 'greediness') using reciprocal roles in symbolic play. A child in non-directive play therapy dictates the issues, pace and actions of the sessions himself, thereby increasing his sense of self-control and the scope of his self-initiated activities. As the above examples demonstrate, when a child engages in symbolic play, either using the therapist in a reciprocal role or using a toy while in the therapist's presence, the therapist will then be able to help him understand and re-experience the emotions, thoughts and actions expressed in play which are troubling him. In this way, then, she will help the child redress harmful and neglected social interaction patterns through symbolic play.

With older children and adolescents who have already developed complex symbolic play the therapist will work at a more advanced symbolic level, fitting into the game or role assigned to her when requested by the child. As therapy progresses, one of the signs of ending (see Wilson *et al.*, 1992 for a fuller discussion) is when the child is able to adopt a reciprocal role with the therapist appropriate to his maturation level. For example, the 12-year-old girl who must always be more successful than the adult (male) therapist in all the activities she initiates, rather than at times cooperating with him or asking him for his help, has not yet developed sufficient mutuality with the therapist and most likely not with other adults significant to her. Harriet, age 8, however, who had initially displayed strong jealousy towards her younger sisters, had begun in later sessions to bring small toys from home that she talked to the therapist about using in play with her sisters. In her last few sessions Harriet began making drawings to bring home for herself and then made more to bring to her sisters and parents, demonstrating new feelings of reciprocity towards family members.

In all of the above examples of therapeutic changes occurring for children in child–therapist communications, it is the child's affect—his interest and needs—which is the child's starting point for

organizing and varying his experiences during therapy. This primacy of affect in therapeutic communication is parallel to normal development: for infants and young children affect normally has a primary organizing function, and becomes increasingly regulated during the child's maturation by cognitive processes which evaluate environmental and internal conditions, assign meanings to events and select appropriate responses. For children with attachment difficulties, often their affective responses have become disorganized or failed to develop appropriately because of either a lack of support or active interference in children's affective responses by attachment figures. Under these adverse conditions young children have great difficulty organizing their responses to incorporate both their own feelings and environmental demands (Crittenden, 1992a). The therapist in non-directive play therapy can be viewed as adapting to children's primary affective responses within the non-complex environment of the playroom. Paralleling normal devlopment, children are helped to (re)negotiate the normal process of learning to increase the organization of their internal, affective responses, thus giving them more adaptability and flexibility in interactions of increasing complexity with the therapist.

INDIVIDUALIZED TREATMENT WITH NON-DIRECTIVE PLAY THERAPY

Throughout this paper we have illustrated the ways in which several current concerns within psychotherapy are directly addressed by non-directive play therapy. First, psychotherapy's current emphasis on relationship psychopathology (Zeanah *et al.*, 1990; Stern, 1985; Peterfreund, 1983) is a primary feature of non-directive play therapy, as seen above in our discussion of infant socialization processes. Second, psychotherapy's recognition of the importance of helping individuals make changes in their current functioning as the primary focus of treatment, rather than basing treatment on recovering the origins of an individual's clinical trauma, has always been emphasized in non-directive therapy (Rogers, 1976). The non-directive therapist reflects the child's *ongoing* feelings, thoughts and actions; the child's past history is reworked and linked with the present and the future only to the extent that the child himself is currently concerned with these areas in his life.

Another related issue in psychotherapy is its need to be more individualized, rather than adhering to preconceived formulations based on the assumed ontogenetic origins of psychopathology (Zeanah *et al.*, 1990). With the method of non-directive play therapy, the child himself chooses his treatment to a larger extent than with most other methods of child therapy because it is the child rather than the therapist who determines the contents and issues to address in his sessions. The therapist's role is to respond to the child's spontaneous and often tentative actions in an assured manner, as the examples of Patrick and Andrew demonstrate, and to help the child develop the method(s) he has chosen for resolving his emotional problems. Therefore, the therapist necessarily needs a working repertoire of many different therapeutic skills at her disposal in order to adapt fluently to the child's choice of method(s) and to combine different methods successfully. Methods such as drama therapy (role-play), art therapy, the World Technique, sand play and structured exercises are some of the methods often employed by the therapist in response to an individual child's actions during non-directive session. Non-directive play therapy is, then, an inherently high individualized means of helping children clarify their chosen emotional conflicts and work towards their own uniquely creative solutions.

CONCLUSION

Even though children referred for therapy have widely divergent problems and past histories, and need a variety of techniques in order to be helped most effectively, these children have all commonly had harmful or inadequate relationships with carers either from the beginning of their development or at some later stage. Non-directive play therapy seeks to redress these abnormal interactive patterns with significant adults and thus to reestablish children's normal social interactions. In so doing, difficulties within the current practice of psychotherapy such as the redressing of a client's relationship psychopathology, the need to help a client make changes in ongoing functioning and the need for more highly individualized treatment are resolved.

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