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The Play's the Thing How the Essential Processes of Therapy Are Seen Most Clearly in Child Therapy

Jay B Frankel, Ph.D.

Analytic child therapy techniques developed as modifications of techniques from adult psychoanalysis. Child therapy continues to be regarded as an adaptation of adult analysis and to give a central place to the methods and conditions of adult analysis, such as interpretation, in its understanding of how therapy heals. I propose that child therapy is not a modified form of therapy and that the essential processes of therapy are fully present in child therapy. In fact, they often may be seen more clearly there than in adult therapy. I suggest two interrelated processes as the essential ones in all analytic therapy. The first is play. I examine several interrelated aspects of play, specifically as they occur in child therapy. These include the emergence and integration of dissociated self-states, symbolization, and recognition. The second process I propose as essential in analytic therapy is the renegotiation of self-other relationships through action. This renegotiation is what can help patients become able to play in therapy when they have difficulty doing so. Since I suggest that action is at the heart of analytic therapy, I go on to consider the role of talking in an action therapy. Finally, I explore the dimensions of mutuality in the relationship between child and therapist,

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Dr. Frankel is Co-Director of the Manhattan Institute for Psychoanalysis. He is also on faculty at the New York University Postdoctoral Program in Psychotherapy and Psychoanalysis and the Institute for Contemporary Psychotherapy, both in New York, and the Contemporary Center for Advanced Psychoanalytic Studies, in New Jersey. He also supervises in the Child and Adolescent Psychotherapy Training Programs at the National Institute for the Psychotherapies and the William Alanson White Institute, both in New York.

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including mutual influence and regulation, mutual recognition, and mutual regression. The intersubjective nature of psychotherapy, which is increasingly appreciated in adult analytic therapy but not in child therapy, provides a fertile context for the evolution of play and for the productive renegotiation of self-other relationships.

From the beginnings of analytic child therapy, its techniques have been developed as modifications of techniques from adult therapy. For instance, child patients are generally unable to fulfill the fundamental rule of adult psychoanalysis—to free associate using words—so play is *substituted* for words, and the analyst interprets the content of the child's play. Also, because the child's ego development is not complete, the analyst must *modify* when and how he or she interprets. Classical child analytic technique continues to give a central place to the methods and conditions of adult analysis, such as interpretation (**Glenn, 1978**; **Chethik, 1989**) and to some extent even neutrality and abstinence (**Glenn, 1978**), in its explanation of how child therapy works, and it adapts its procedures to the demands of working with children only reluctantly.

I suggest that child therapy is not a bastardized form of therapy at all. I think that the essential processes of therapy are *fully* present in child therapy and, in fact, often may be seen more clearly there than in adult therapy.[1] But what are these “essential processes of therapy”?

I take as essential those processes that are sufficient to achieve an analytic result, which I understand as the integration and acceptance of disavowed or dissociated aspects of experience (e.g., see **Freedman, 1985**; **Bromberg, 1994**; **Fonagy and Target, 1996**). I make the case that there are two interrelated

processes that are essential for all psychoanalytic therapy: play and the renegotiation of self-other relationships through action. Play is inherently therapeutic, as I discuss. Renegotiation can take place through play, or if the patient cannot yet play, it can help to make play possible. I look at several aspects of play, including the emergence and integration of dissociated self-states, symbolization, and recognition. The provisional attitude of play, which

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[1] Jacobs (**1996**), in a recent article, looked at how child therapy can help us think about work with difficult adult patients. However, I think child therapy lets us see what goes on in all psychotherapy, not just with difficult patients.

I discuss at length, runs through all the aspects of play; it also informs the tone of negotiations between patient and therapist, and it makes mutuality possible. I also consider the role of talking in an action therapy.

I go on to talk about mutuality in child therapy. The play that emerges in therapy is very much the creation of both child and therapist, not only the child, and the therapist is known to the child and not anonymous. This is true regardless of the therapist's theoretical orientation or technique. Additionally, a striving toward mutual recognition is inherent in the therapeutic process. These viewpoints are increasingly appreciated in adult analytic therapy[2] but not in child therapy.

Play

In this section I discuss play not as preparation or as a vehicle to deliver other essential processes, but as *itself* an essential process of therapy.[3] Winnicott (**1971**) defined psychoanalysis as “a highly specialized form of *playing* in the service of communication with oneself and others” (p. 41; italics added). “Psychotherapy has to do with two people playing together” (p. 38; original in italics). He was talking about therapy with adults as well as children. Ferenczi, in a 1931 paper called “Child Analysis in the Analysis of Adults,” saw even earlier how adult therapy is often play therapy.

What is play and how is it therapy? Writers on the play of humans and animals (e.g., **Groos, 1901**; **Erikson, 1950**; **Lorenz, 1971**; **Bruner, 1972**) have agreed that freedom from external goals, pressures, and threat (**Lorenz, 1971**, p. 88, borrows Bally's phrase, “the field released from tension”) allows greater curiosity, exploration, spontaneity, novel behavior, and creativity. These facilitate learning and are characteristics of play. Play implies a positive attitude toward the unknown (**Lorenz, 1971**) and pleasure in an activity for its own sake. These are the conditions and characteristics of play, but the act of playing is by

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[2] For instance, see Hoffman's (**1983**) review of the therapist's inevitable influence and transparency in adult analytic therapy and Aron's (**1996**) recent exploration of mutuality in psychoanalysis.

[3] The view that playing in and of itself is therapeutic has recently been gaining adherents (e.g., **Briggs, 1992**; **Drucker, 1994**; **Slade, 1994**; **Krimendahl, 1996**).

nature an act of pretending (e.g., **Groos, 1901**; **Fonagy and Target, 1996**) as the player tries out new roles, and it is pretending that I focus on.

Pretending means being in two places at once, straddling two self-states. Think of a play in the theatre. The actors are themselves, but also the characters they impersonate (see **Briggs, 1992**). Another way to say this is that play is a bridge from the perceptual to the imaginary: In pretending, we both equate and differentiate the inner and outer worlds (**Vygotsky, 1933**; **Bateson, 1955**; **Ogden, 1986**; **Fonagy and Target, 1996**). In therapy, the “characters” people come to “play” are those they have not been able to come to terms with: aspects of themselves they haven't comfortably been able to own or to bring out into the world, or the parts that do not seem to mesh well with other people.[4] Play is a way of approaching a problematic part of ourselves, something in ourselves that we do not yet fully accept, and of trying to find a place for it in our lives. Through play, we integrate it into our experience of ourselves and into our interpersonal relationships.

Playing gives us a sense of control over this problematic part of ourselves. We can be something and say we are not. In play, we can approach a difficult part of ourselves precisely because we can also disavow it.[5] Kaplan (**1989**) made a similar point about dreams: their usefulness in therapy lies in their being something that feels part of ourselves, yet other than ourselves. Play lets us get to a disavowed piece of ourselves in our own way and at a pace we can control, hence with a greater feeling of safety.

Winnicott's (**1951**) idea of transitional space as the basis of play proposes that, through play, we can take something from our inner world and make it part of the world we share with other people (**Winnicott, 1971**). And vice versa; in play we take objects from the world and use them symbolically to represent and realize what is in our minds. Play, Winnicott reminded us, takes place not in our minds, but in outer reality. It turns private thought into action. As we bring this

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[4] First (**1994**) described how young children use play to come to terms with emerging developmental capacities as well as difficult interpersonal situations.

[5] Groos (**1901**), Bateson (**1955**), and van Hooff (**1972**) observed that play always includes a message—a "metacommunication," to use Bateson's term—that what is being enacted should not be taken seriously.

hidden part of ourselves out, we make ourselves that much more at home in the world (see **Freedman, 1985**).

Therapy is designed for play. The therapist offers herself, in a broad sense, as a transitional object, not as someone permanent in the patient's life. The patient does not need to worry about the real-world consequences of telling a therapist, the way one would be concerned about telling a parent, teacher, boss, spouse, or friend. This frees the patient from external goals and pressures—a prerequisite for play. The therapist is a real person for the patient, but as a transitional object she is also someone the patient can *use*. The therapist can be treated by the patient as the other character necessary for the play that must be performed. The patient can project onto the therapist or direct feelings at her, trusting that the therapist can leave the theatre when the curtain comes down and return for the next performance ready for whatever role is assigned. Therapy offers a world for the patient to construct and reconstruct.

Integrating Self-States

Bromberg's (**1993**, **1994**, **1996a**, **b**) ideas about self-states are important in terms of defining the structure of the play that happens in therapy. He made the case that consciousness consists not of a single experience of self, but of a multitude of "selves," each discontinuous from the others. We live our lives shifting from state to state.

Each self-state contains a particular experience of self in relation to a perceived other, including specific interaction patterns, state-dependent memories, cognitions, moods, and affects. In a word, each self-state contains its own reality. The different self-states that make us up contain realities that do not always fit together with each other. They may even oppose each other, leading us to feel and to appear to others to be different people at different moments.

Some self-states are less accessible to us, are disavowed, are dissociated, or find less of a comfortable place in our day-to-day living. Such self-states press for expression in the relatively accepting therapy situation, and their integration becomes the important task.

How does the therapist foster this integration? Bromberg (**1994**) described the analyst's task, not as "understanding" the patient in an intellectual way, but as knowing the patient in a more direct and

immediate way, "through the ongoing intersubjective field they are sharing at that moment. It is through this medium that an act of *recognition* can take place" (p. 524; italics added). I discuss the role of recognition in more detail later.

As the analyst, through the act of recognition, "acknowledge[s] the divergent realities held by discontinuous self-states in the patient while simultaneously maintaining an authentic dialogue with each," these states become more real for the patient (**Bromberg, 1994**, **p. 517**). What was background, what had gone by not attended to, comes into prominence. These states begin to get noticed, become elaborated, articulated, and enacted more openly. Previously disavowed aspects of oneself become symbolized through their enactment (as I discuss shortly) and are experienced more fully (see **Freedman 1985**, **1994**). In this way, the patient becomes "*able to embrace the full range of his perceptual reality within a single relational field*" (**Bromberg, 1994**, **p. 517**; italics added). The goal is to be able to experience, accept, and encompass conflict and discontinuity, not to make them disappear.

This is playing, isn't it, bringing dissociated states into communication with each other in an interpersonal relationship? The therapist's openness to the patient's playing makes the therapeutic relationship a safe place to do this. The therapist's playing with the patient is an act of recognizing these states—of engaging them in a "dialogue," to use Bromberg's (**1994**, **p. 517**) word—and this helps these

states become an acknowledged part of the relational field shared by patient and therapist. Through playing, these states become realized, integrated, and accepted into the patient's experience of himself.[6]

Child Therapy. Therapists just starting out at child therapy, and sometimes the rest of us too, feel guilty about "just playing" with our child patients. We feel we should be doing something "more therapeutic." What are we doing when we just play with a child? Let's look at some playing.

Seven-year-old Jim came to therapy because he was anxious, easily upset, and not fully participating either in school or social relationships.

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[6] It was Ferenczi who, in 1931, first described how play between adult patient and therapist is essential in engaging and integrating the patient's dissociated states. Recently, Corrigan (**1996**) applied Bromberg's ideas about self-states to play therapy with children.

After an initial, tentative phase in his therapy, he has developed a pattern. Session after session, he begins by cautiously checking out various spots in the room, as if to reassure himself that all is as he had left it. Then, more relaxed, he rearranges the furniture—chairs, cushions, end tables—and makes a "nest" for himself. I am quiet and let him be. Soon, he starts making wild animal sounds. He becomes a predator, a lion, and expects me to whimper and retreat, like cornered prey. He smiles when I do. Then I, too, become a strong, tough animal, and we have a battle. He never tells me to do this, but I do, certainly partly out of my own enjoyment as well as my sense of what the game is about, which is continually shaped by his nonverbal feedback. Near the end of the session, once more a boy, but more lively—not the cautious boy he was at the beginning—he may be a little disobedient. Throughout the sessions, he does not talk much and he will not respond if I inquire.

Jim's typical session shows clearly how play encourages dissociated self-states to become symbolically expressed through their enactment—for instance, his aggressive self became a lion and his vulnerability became me playing a frightened animal (**Caspary, 1993**, and **First, 1994**, discuss how child therapists often take as their play roles the unwanted, disavowed parts of their child patients' personalities.) In this way, Jim was able to approach these states, both of which were uncomfortable for him and not well integrated into his sense of who he was.

In Jim's life outside the treatment room, he has shown steady improvement. The psychologist at his school called me to talk about his progress. I told her I sensed that he approached the sessions with a sense of purpose, that he was working at something in the therapy. She asked what that was. For a moment I was stumped. Jim and I had never formulated the meaning of our play out loud (nor had I felt I could definitively formulate it to myself). I occasionally found a word to label the atmosphere of the play or to say how my character, or his, was feeling. Mostly, we just roared. With Jim, playing was therapy. Interpretive comments *at this phase* would have meant taking a break from playing and might have made the therapy a less welcoming place to play.

Winnicott (**1971**) said that "children play more easily when the other person is able and free to be playful" (pp. 44-45). Agreeing to play with someone, to enter his or her world, is an indication of a

willingness to accept and an interest in understanding. But when we *enjoy* playing, we convey more than this. We are telling the child we *identify* and are *complicit*: I know you, and I am like you. The pleasure we take in playing with our child patients communicates our sense of connection to the child and our *personal* knowing and acceptance of the child, as with my lion boy.

How Self-States Emerge in Children Compared with Adults. It is easy to recognize discreet self-states in children, as we saw in Jim's case. With children, self-states shift in bolder relief. State shifts often announce themselves with new games, new characters, new body postures, or new voices. Children, inexperienced as they are in social graces, are less likely to have developed a socially acceptable mask or to have learned smooth segues from state to state. Their consciousness is more obviously discontinuous. A young child who is suddenly disappointed is more likely to break out in tears than an adult, who may hide the shift. With adults, self-states may be more masked and shifts between them more subtle. Children also feel less compelled to impose a false continuity on their experience. They never begin a session by asking, "What were we talking about (or playing) last session?" the way adults sometimes do.

Therapy with adults usually relies more on words than child therapy. For several reasons, a primarily verbal treatment may make it harder for the observer to see the workings of the essential processes of therapy. The sophisticated use of words allows a more complex (and therefore harder to decipher) interweaving of states than physical actions do. Also, words, by nature, are more abstracted from

experience than actions. Unlike motor actions, they often don't carry with them the sense of the immediate experience of what they refer to, although, of course, they can. Finally, words are simply not the native language of many states, especially dissociated ones, which remain unsymbolized.

The therapeutic processes at work in a child therapy whose currency is play can be seen more clearly because they happen more simply, are often less disguised, and generally are expressed through physical action.

Let's look at how self-states emerge with adults and children, respectively, in therapy. A man, my patient, is describing his adversary in a business deal. He is making the case that he had been forced to take a

hard stand because the other man was untrustworthy. It takes a little while until we can establish that my patient relishes being tough, that it is an experience with personal meaning for him. His shows of toughness toward me are even harder to pin down given his good manners. Usually they look more like the behavior of a good host—gracious but in charge.

Similarly, a very civil, mutually caring married couple who consulted me had the same interaction over and over. The wife would explain her feelings in detail. Her husband would acknowledge what she had said with a brief summary and might also explain his own feelings, though also briefly. Then the wife would rephrase herself, as if he hadn't understood. Why did she repeat herself? He had seemed to understand what she said, although his response to her was a bit patronizing. Not until a little while after this pattern had become clear did it hit me what was happening. I asked them, “Are you two having a fight?”

Child therapists will immediately know how such examples would play out with kids: more directly. When a boy, for example, wants to show he is tough, he may order the therapist around: “Slave, get me a piece of paper!” If he wants to make a mess, he will, and if he wants to pick a fight, it will likely be a pillow fight or else open defiance: He won't stop pulling the tissues out of the tissue box or he won't leave at the end of the session. Even with a more inhibited child, the wish to be tough, to make a mess, or to fight is likely to be more transparent than with an adult who feels uncomfortable doing these things.

Children as a group seem to play more readily than adults, to be more able to straddle their inner and outer worlds: They seem able to bring their inner worlds into the therapeutic relationship with full vividness and intensity without losing touch with interpersonal realities.

Symbolization

Symbolization is the process through which unintegrated experience is transformed into communicable, understandable, “thinkable” thought (**Freud, 1915**; **Freedman, 1985**; **Greenberg, 1996**). As we symbolize, we come to own what has happened to us and how we feel. As such, symbolization is bound up with the emergence and integration of

disavowed states, the therapeutic effects of self-expression and the evolution of play. When we cannot symbolize an event that is traumatic, that overwhelms us or causes us great anxiety, symptoms may express, but do not clearly communicate, to others or to ourselves what this experience felt like and what it means to us. Symbolizing the experience allows us to process it, come to terms with it, and free ourselves from its grip. LaPlanche and Pontalis stated that “it is in the symbolization of disjunctive experiences that psychoanalysis effects its cure” (as cited in **Freedman, 1985**, **p. 335**).

When we symbolize an event or reaction, we differentiate it from the background mass of inattended and unarticulated experience (**Freedman, 1985**). For instance, trauma victims, by talking about past traumatic events in therapy, gradually are able to remove the taint of these traumatic feelings from current, unrelated, benign events (**Bromberg, 1994**). As we symbolize an experience, we gain a greater awareness of the actual nature of external reality as well as a greater sense that our experience is our own construction (a sense that **Ogden, 1986, chap. 8**, called “subjectivity”). Along these lines, symbolization helps us to see other people more clearly and to detach our experience of ourselves from our identifications with them. This results in more differentiated relationships with other people.

The opposite of this, clinically, are patients who experience, and sometimes insist, that their perceptions are the only correct ones and their feelings are the inevitable and only possible response. Phillips (**1996**) tells us that Winnicott once said, “madness … is the need to be believed” (p. 34). All of us, I think, have some aspect of our lives where we function this way, where our perceptions feel absolute and we lose our sense of subjectivity. The provisional attitude that characterizes the sense of subjectivity is at the heart of play.[7] Symbolization is how we acquire it.

The symbols through which we become able to think about and accept ourselves can be words. Words carry the capacity for abstraction,

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[7] There is an interesting parallel between the lack of urgency—"the field released from tension" (Bally, as cited in **Lorenz, 1971**, p. 88)—that is a necessary condition for play and the psychological distance and lack of urgency that characterize the sense of subjectivity. The "field released from tension" facilitates play, and then play becomes the matrix in which symbolization and the sense of subjectivity develop. Bruner (**1976**), in his review, concluded that play in humans and animals fosters restraint in place of aggression and impulsivity.

so they allow us to consider experiences in the framework of a past and a future and to imagine categories, hypotheticals, ideals, and alternatives (Church, as cited in **Sacks, 1989**, p. 44). But the action symbols typical of children's play (and of adults' enactment in the transference), being both highly evocative (i.e., they communicate an experience, a feeling, on a gut level) and ambiguous (and therefore "deniable"), may be the bridge by which we begin to approach, express, and accept disowned aspects of ourselves (cf. **Freedman, 1985**, **1994**).

Freedman (**1985**, **1994**) detailed how symbolization in adult psychoanalysis is a dynamic process that proceeds through stages, beginning with an area of functioning where tension states are discharged before they can be noticed or articulated, through a phase where fragments of symbols emerge, and then to a stage of true symbols that, according to Freedman, contain and integrate all the conflicting aspects of the experiences with which one struggles and which are understandable to oneself and to the other person.

I have often observed a sequence similar to Freedman's with vivid clarity in child therapy. A child often begins therapy enacting his presenting symptom in his behavior with the therapist. An aggressive boy will be defiant toward the therapist. A parentified child, or one who is anxious and inhibited, may be very polite and show excessive concern for the therapist's sensitivities. A withdrawn girl will avoid direct relatedness to the therapist. Early in therapy, there also is often a quality of shifting from one activity to another without a sustained focus, perhaps in an anxious way—what Erikson (**1940**) described as play disruption— or in an exploratory way, with nothing in the therapy situation having yet "grabbed" the child. In either case, the child does not yet allow sustained affective experience or meaningful connection with the therapist. Nevertheless, the child may be growing to like and feel comfortable with the therapist.

At some point, however, there is a shift. Elements of the child's engagement of the therapist and the child's play begin to gain importance, until a compelling, cohesive, and *clearly symbolic* activity coalesces in the child's play. This activity seems to be a clear metaphor for everything bound by the child's presenting symptom: her disavowed feelings, problematic identifications with others, the dilemmas she faces in important interpersonal relationships, and the resolution she has developed to cope with these.

In symbolizing these aspects of self, the child makes space for herself at some distance from her "reflexive reactivity" (**Ogden, 1986**, p. 209) to pressures and anxieties. Symbolizing through play also places the child in a new relation to the therapist. Before, the child enacted her conflicts in her relationship with the therapist and reacted to the therapist mainly as someone to manage, fend off, or struggle with. Now, the child seems to have found a way to communicate *about* her conflicts, and the therapist can be experienced as benevolent, an intimate with whom the child may share her concerns.

In my experience, the achievement of this compelling symbolic activity often seems closely correlated with symptomatic improvement, even in the absence of interpretive linking of the play to symptoms or family dynamics. Chethik (**1989**, chap. 3) described a similar sequence of events.

Case Example of the Evolution of Symbolization Through Play. Lisa, a six-and-one-half-year-old girl, had become increasingly withdrawn in school and moody at home. In school, she often hid behind others or huddled in corners, sucking her thumb and twirling her hair. She was tentative, showed little interest in her schoolwork, and looked sad. Often, on school mornings, she said she did not want to leave the house. At home, she was often sullen and prone to tantrums. She was sometimes nasty toward her somewhat anxious mother, but seemed nervous when apart from her mother. Lisa's difficulties had worsened a few months earlier after her grandmother moved to a distant city, although these patterns existed before this event.

At the beginning of therapy, Lisa was shy, cautious, and vigilant toward me. She was tentative, not only toward me, but also in handling the toys. In her first session, she wanted her mother to come into the therapy room. She seemed to "take back" signs of aggression—for instance, picking up a gun briefly and then putting it down or drawing a picture of herself that had more dots than her picture of her younger

sister, which she first was glad about, and then giving her sister's picture more. During the early sessions, Lisa continued to be quite anxious and inhibited. Although certain fragmentary play themes emerged, there was a lot of shifting from one activity to another.

After a time, her doll play and the story fragments she told became more aggressive. A baby knocked down a parent. Yet there were often sequences where her play first would be bold and then meek and babyish, as if her aggression scared her. She gave a clue to her aggression, and possibly to her subsequent babyishness, as she told a story where everyone loved her little sister. Perhaps she felt she had to renounce her aggression and be little like sister to be adequately loved. Her stories and play often suggested a losing battle for her mother's attention, as, for instance, when she made up a story in which a family forgot their older daughter while going to watch their younger daughter's class play.

In her play, Lisa seemed anxious about attachment to outsiders and saw them as a threat. She told stories about dangers, accidents, and lost children. Although Lisa had become more openly interested and affectionate toward me, with more physical contact and an increasing sense of intimacy, she often asked to stop coming to therapy, though in a perfunctory, unconvincing way.

Play activities continued to shift frequently, giving the sessions a feeling of a lack of cohesiveness. No activity yet seemed to compel Lisa or to become progressively developed, except in fits and starts.

The school was now reporting minor improvement, and Lisa resisted going to school less than before. There were also fewer tantrums at home, but her mother said that Lisa had become more rude toward her mother. Lisa had begun making threats that upset her mother and to which her mother would often give in.

Hide-and-seek became a regular activity in sessions. One day, Lisa curled up comfortably under a table with a toy gun. After winter vacation, Lisa was reported to be withdrawn, inattentive, and self-absorbed at school. In sessions, she began to talk about her anxieties about school: She doesn't know a lot; someone else may scribble on her papers. Themes of stories she told in sessions continued to include avoiding aggression and her parents losing her.

Then, in one session nine months into the therapy, Lisa came in wearing her hood over her head. We played hide-and-seek. Then she made a very elaborate “tent” out of chairs, pillows, end tables, slipcovers, and other objects from the office. In the tent, Lisa was isolated, but she also seemed to feel cozy and safe.

From that day on, tent-making became the primary activity of every session. Though her tents were private, I could look in and talk with her. I often let her play in her tents undisturbed, which felt right. Soon her tents became even more elaborate and private. She brought in dolls and toys. She had us each make our own tents, although the focus was always on hers. We could talk back and forth between our tents.

Almost immediately after the tent-making began, the school started to report that Lisa was coming out of herself. She was doing well and working hard. She sometimes still withdrew, although this occurred much less. She became more assertive in class. She began writing stories on her own and even volunteered to read her work in front of an assembly with the whole school present.

Her improvement seemed directly related to her articulation of symbols through play. I had interpreted little beyond labeling what she was doing and might be feeling in the play activities. I had made only very general, cautious (and rare) allusions to her family life, and there had been no explicit linking of her play to specific family relationships or events (I sensed that this would be an impingement).[8]

Lisa's tents continued to become more private. By this point, they were closed up almost totally. She made her tents herself, and only occasionally asked for my help to bring her something or take out her garbage. Every session began with her happily exclaiming, “Tent time!”

The tents soon became more open and less seclusive—reflecting the changes in our relationship, it seemed—and Lisa began to invite me into her tents to play games. They then became covered “mazes” that forked. We took turns crawling through while the other guessed which fork we were traveling through. The mazes became more elaborated as she put booby traps in them (tissue boxes) that we had to avoid as we crawled through. Lisa played with enthusiasm and excitement. She seemed self-confident and more openly attached to me.

Soon, we shifted to separate but connected tents. We began to have gunfights against each other, and the tents became places to seek cover and safety. The gunfights became wild and joyfully aggressive, and she

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[8] My work with the family was not extensive, and there were no changes at home of which I was aware which seemed to account for her improvement.

became openly competitive with me. Her mother reported that Lisa was now getting more invitations for playdates and was also calling other children more often.

The Meaning and Function of the Tent Symbol. As I see it, Lisa's tents represented her conflicting needs, on the one hand, for attachment to a mother she experienced as somewhat unavailable—through an identification with her mother's wish to withdraw and compliance with her mother's wish not to share her—and on the other hand, for space, privacy, and a rejection of her need for a mother who Lisa saw as anxious and impinging. That is, the tents represented her problem. But unlike the earlier enactment of her withdrawal, they also represented a new, satisfactory solution, which was to define her own space, privacy, and aggression within the larger context of an intimate relationship, something she did not feel gained comfortable recognition and appreciation from her mother. Lisa's relationship with me, mediated through the symbol of the tents, included contact that did not lead to impingement and privacy and aggression that did not lead to abandonment. Further, while loosening her identification with her mother, Lisa was still able to bring her mother along into this new relationship—by representing her symbolically in play—and thereby not feel she had abandoned or lost her. In these ways, Lisa's articulation of the tent symbol became for her the discovery of a new, tolerable, and satisfying way to experience her relationships with others—a way that included the integration of urgent but conflicting wishes that previously felt unresolvable.

The creation of the symbol of the tent within the therapy also allowed Lisa to experience a new aspect of herself. Lisa had previously been absorbed in her defensive adaptations to others, which left little space for her to feel herself to be other than reacting to pressures. Developing her symbol allowed Lisa to gain some measure of psychological distance from her defensive adaptations. In the process, she became able to find a sense of herself distinct from them—one that felt more authentically and uniquely herself and that she could experience as a source of spontaneity and creativity (see **Winnicott, 1960**; **Wolstein, 1988**). Her new interest in writing stories at this time speaks to an emerging self-expression and creativity.

Recognition[9]

"Recognition," Benjamin (**1988**) says "is that response from the other which makes meaningful the feelings, intentions and actions of the self. It allows the self to realize its agency and authorship in a tangible way" (p. 12). This is Bromberg's point in his discussion of the emergence of self-states in therapy: Disavowed self-states become real for the patient, accepted and integrated into the patient's idea of who he or she is, only as these states come into the relationship with the therapist and are recognized in some way by the therapist.

Racker (**1968**) proposed that analysts continuously identify with their patients—which is a way to know them intimately—either in a concordant way, by feeling like the patient feels, or in a complementary way, taking the opposite role. I suggest that if recognition relies partly on identification, which I think it does, we can think of it as coming in these two forms: concordant and complementary.

When patients engage us so that we feel we can put ourselves in their position (more accurately, in *one* of their positions, one of their self-states), we recognize them in a concordant way. As therapists, we often actively seek a state within ourselves, that seems to have some connection to what the patient is feeling. Other times, we find ourselves feeling, and perhaps behaving, parental, hostile to the patient, controlling, compliant, submissive, or powerless—complementary in some way. Also, setting limits, taking on the patient's resistance, confronting the patient, and opposing something the patient is doing are complementary forms of recognition. No less than the more familiar, concordant form of recognition—and sometimes more—these complementary forms recognize a self-state, notice it, take it seriously, and so give it existence in the behavioral dialogue (see **Singer, 1965, chap. 7**).

I am leading to the idea that playing with our child patients *is* recognition.[10] Most basically, we know the game that the child, or the two of

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[9] Ideas about the role of the therapist's empathy, "holding" the patient, "being at one" with the patient or "containing" aspects of the patient fall under the broad umbrella of the therapist's recognition of the patient.

[10] My discussion of recognition emphasizes it as inherent in the therapeutic relationship, not as a procedure. Similarly, Bromberg (**1994**) appreciated self-disclosure by the therapist when it evolves within a particular therapy but criticized it when self-consciously applied as a technique; in the latter case, it lacks authenticity.

us together, have invented; certainly we know the game in our gut, even when we cannot explain its rules. Knowing the game, we sense who the child is. We may play a concordant role—be on the same side in a war, literally in the same boat or under the same tent. Often we play a complementary role: we are battling the child or are his slave or his boss, or we are restraining the child. In all cases, there is recognition. Playing with the child, allowing a spontaneous engagement rooted in our unconscious responses to her, is a way of conveying recognition long before we have the words for what we know unconsciously about the child.

Whatever identifications we have with our patients must be tempered by our own sense of subjectivity. We must hold onto the sense that our view of our patients is provisional so that we do not impose it on them. In other words, our identifications with our patients must be playful. Without this, our identifications constitute impingements, not recognition.

Recognition entails identifying with the other, but it also requires acknowledging the other's differences from ourselves (**Benjamin, 1988**, p. 9). Beyond accepting the other's differences, granting that the other is a person separate and distinct from us means also granting that we cannot ever fully know the other (cf. **Bion, 1970**; **Wolstein, 1988**).

Play's meaning, as I suggested, is inherently not fully knowable (cf. **Briggs, 1992**). Unlike adult therapy, where it might *appear* to an observer that the task is to piece together an intellectual understanding—to *analyze*—in child play therapy, a naive observer probably would not guess this to be the task. The ultimate unknowability of the child's play needs to be respected for the child to feel treated as a unique, developing being. The therapist's joining in with the child's play communicates this respect, because the therapist partakes of the activity that, by its nature, elevates the process of creativity, and therefore transformation, and does not pretend to be able to reduce its meaning to something that can be fully captured by words. Therefore, when the therapist accepts and joins the child's play, he or she acknowledges what is unknowable in the child and so recognizes the child's differentness, not only from what the therapist *is* but from what the therapist can even *imagine*. This is another way to see how play therapy may reveal to us more transparently than adult therapy does the basic nature of the therapeutic task and the therapeutic relationship.

The Inability to Play

Patients often bring in something urgent through action, not words, but without the psychic space to explore it. They simply demand the “right” response from the therapist and cannot brook even a slight deviation from this. At these times, patients do not have any distance from their feelings or actions and cannot back off from their demands. Other patients seem tense, on their guard, not trusting, or depressed and uninvolved. All these patients are not able to play. I think that all people are unable to play at some times, in relation to what are for them urgent issues (see **Frankel, 1993**).

After Winnicott (**1971**) said that “psychotherapy has to do with two people playing together,” he added, “The corollary of this is that where playing is not possible then the work done by the therapist is directed towards bringing the patient from a state of not being able to play into a state of being able to play” (p. 38). But Winnicott did not prescribe how the therapist does this.

What allows a child to play? As noted earlier, play requires freedom from coercion, threat, or pressure. This means that for the child to play in therapy, the relationship with the therapist must feel safe. Children often probe the therapist to find out if the relationship is indeed safe, putting forward their unconscious anxieties about the therapist in the form of behavioral “tests” (**Weiss, Sampson, and the Mount Zion Psychotherapy Research Group, 1986**). They challenge or comply or hide from the therapist, hoping the therapist will behave differently than they expect and fear. If the therapist does, they may begin to *feel safer*. The children also test to see if the therapist *can understand* them, *wants to engage* them, and *is committed* to them. Interpretation can sometimes be useful in establishing the therapist's potential to understand and in disconfirming the children's unconscious anxieties. The role of behavioral tests is discussed at greater length in the following section.

Renegotiating Self-Other Relationships through Action

Renegotiation through action is the second broad, essential process of therapy (see **Mitchell, 1991**; **Pizer, 1992**, **1996**; **Aron, 1996**). It can

take place through play; at other times, it is not playful. When play is not possible, this kind of renegotiation is the crucial process that creates conditions in which it will feel safe enough to play, as I just noted.

I begin the discussion with Greenberg's (**1996**) recent challenge to the older idea that analysis works through communicating information by talking; the patient free associates and the analyst interprets. He traced the evolution of the competing idea that analysis is about action and focused, among others, on the contributions to this point of view by Sullivan and Levenson. Sullivan's idea of the therapist as participant-observer requires seeing the therapist as a constant participant in the relationship with the patient. Levenson emphasized that "analysts … inevitably act within their patient's transference paradigm, cocreating and re-creating the patient's history" (cited in **Greenberg, 1996**, p. 208). The resulting "creation was not necessarily something to be verbalized, interpreted, even understood…. The act is not fodder for the analysis. The sequence of actions, one unfolding into and out of the other, *is* the analysis" (**Greenberg, 1996**, p. 208). Along these lines, Bromberg (**1994**) has suggested that "dissociated domains of self can achieve symbolization *only through enactment in a relational context*" (p. 535, italics added; also, see **Freedman, 1994**).

Lachmann and Beebe (**1996**) suggested a model of therapeutic action precisely along these lines, based on the sequence of actions between patient and therapist. They start with the proposition that the organizing principles that govern the evolving relationship between mothers and infants, that have been derived from close study of videotapes of their interactions, provide a model with which to understand the patient-analyst relationship. Like mother and infant, analyst and patient are engaged in an ongoing mutual regulation of their relationship that results in characteristic, expectable patterns of repeated interactions. These interactions are regulated by both participants through "subtle nonverbal behaviors" (p. 4) as well as through verbal exchanges. The patterns that are structured in these ways "contribute … *directly* to the formation of representations and internalization" (p. 5). That is, the interaction between patient and therapist "can promote new expectations and *constitute a mode of therapeutic action*" (p. 5; italics added). They gave as an example the observation that "repetitive themes of the patient (e.g., expectations of nonresponse, indifference, or rejection) are engaged, [and] potentially disconfirmed…. Through

this process these themes are altered" (p. 5). They proposed therefore, that even "ongoing interactions *that are never verbally explored or addressed* can … potentially alter the patient's expectations" (p. 5; italics added). They also discuss a counterposing principle, the principle of "disruption and repair," in which "violations of expectancies and ensuing efforts to resolve these breaches" (p. 5) also contribute to the reorganization of the patient's internal representations. We can think of Lachmann and Beebe's model as an operational description of how inner self-object relationships are renegotiated through the therapeutic relationship.

Like Lachmann and Beebe, Weiss et al. (**1986**) saw the interaction between patient and therapist as having a key role in the renegotiation of the patient's self-other relationship. Through their research program, they demonstrated how patients continuously test out unconscious, disturbing, pathogenic beliefs in their relationship with the analyst, trying to determine whether they are safe with the analyst, and hoping to find their pathogenic beliefs disconfirmed. Levenson (**1972**) earlier proposed a similar idea: the heart of the analytic process is the patient's effort, and temporary success, at "transforming" the therapist into a problematic figure in the patient's life, and the therapist's resisting this transformation.

I agree with these authors that people come to therapy to try to resolve interpersonal dilemmas that seem insoluble and that they impose these dilemmas on the therapist in hopes that the therapist will have a better solution or that a better solution will emerge. The solutions that patients have thought of in the past fall somewhere on the sadomasochistic continuum. Both sadistic and masochistic positioning may appear to offer a way out, a way to gain control of the situation. A young woman who cannot make romantic relationships work may think, "I'll just have to be nicer, more agreeable, hide my own feelings more than I do," or alternatively, "I'll act tough, I won't give him the time of day, I won't put myself in another situation where I can be hurt." With children, submissive and compliant or dominating, bullying solutions are even more obvious. Sadomasochistic solutions are the alternative to intersubjective relationships, in which both oneself and the other person can be accepted as separate and valuable people, differences can be acknowledged, and one person need not be diminished for the sake of continuing the relationship (see **Benjamin, 1988**,

and **Frankel, 1993**, for more detailed discussions of this). I think that in interpersonal dilemmas sadomasochism is the common thread of all solutions which are inherently doomed to fail.

Passing the patient's test in a therapeutic way ultimately means finding an intersubjective solution. Because the therapist's subjectivity must be included in the resolution, a requirement for passing the test is the authentic, personal involvement of the therapist, which, by nature, includes unconscious, irrational elements of the therapist's personality. A key element of the testing process is the patient's effort to evoke such personal involvement by the therapist (see **Levenson, 1972**). I previously described this process, which I see as inherent in therapy and central to therapeutic action, as a cycling from an unconscious collusion toward a more genuine intimacy (**Frankel, 1993**).

This type of testing is usually easier to observe—literally to *see*—in child therapy than adult therapy because it often takes place through physical as well as psychological action. A child may threaten to walk out of the therapy room during a session or refuse to leave when it is over. He may curse at the therapist. Another child may isolate herself or play in a way that prevents the therapist from seeing or hearing what she is doing. At these times, the child is paying close attention to the therapist's response.[11]

An adult may also resort to gross, behavioral forms of testing, but this is likely to happen when the viability of the treatment itself is in jeopardy, or else it signals that a long, difficult treatment lies ahead. Adults may do such things when they are near the end of hoping that anyone can cope with them. Children more often do them with a

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[11] In child therapy always, and sometimes in work with adults, positioning oneself in response to the patient's pressures also means positioning oneself within the current family system. Pressures come from the family, not just the child; in these instances, too, the child observes the therapist's response. The child pays close attention as he observes in a family session, overhears a parent's "out of earshot" comment to the therapist, or infers from the therapist's or parent's behavior the therapist's response to such important questions as, With which parent has the therapist become allied? ("My husband doesn't think much of psychotherapy, doctor.") The child studies not only how the family boxes in the therapist, but what the therapist *does* about this. Other similar issues are, What is the therapist kept in the dark about that the child knows? How are power and authority issues negotiated between parents and therapist? How do family members try to establish their position on these and how does the therapist respond?

greater faith that someone can and will meet their needs, and they do them routinely, as all parents know.

It often happens that the beginning period of child treatments is characterized by such gross, behavioral testing before the child will allow herself to become more engaged, relaxed, and playful in her interactions with the therapist. Other children begin therapy acting compliantly toward the therapist, either talking in a "grown-up" manner rather than playing in a more natural way, or else remaining tense, neither playing nor talking freely. This "lack" of action is, of course, also an action and a test for the therapist: Does the therapist need the child to be grown up, to speak the therapist's language, or will the therapist be more responsive to the child's hidden wish to act like a child? Can the therapist be patient or will she become anxious or pushy? Will the therapist continue to be attentive to the child's implicit communications?

In later phases of therapy, if the therapist has minimally passed the early tests and has shown by his response some beginning understanding of the child's difficulties and the ability to cope with them, children test out their pathogenic beliefs in a more elaborated and increasingly playful way. An eight-year-old boy, Joey,[12] was brought to therapy because he was defiant and disrespectful, went out of his way to be nasty toward vulnerable people, was preoccupied by sexual thoughts, and expressed occasional suicidal ideas. Joey came across more like a teenager than a child. He began therapy repeatedly threatening to walk out, cursing and making obscene gestures at me, and otherwise being defiant. When limits were set, bait not taken, and provocations not engaged (this was not so easy—he was a practiced provocateur), he began to bring this side of himself to therapy in a more playful way. He called my telephone answering machine from the second phone in the office and cursed at the answering tape rather than at me. He quickly developed a new "tough guy" phone voice for doing this. Inquiry revealed that this "tough guy" had a name, "Shitface," which he had been given, he said, because his parents hated him. Then, to demonstrate, he stepped on a baby doll. In subsequent sessions, Joey developed other characters as proxies for aspects of

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[12] As with many of the cases I discuss in this article, for purposes of clearly presenting my points I omit a discussion of my work with the family.

himself and very tentatively began to express warm feelings for me. He called my answering machine and said, “You're smart. You're pretty … pretty ugly!” Subsequently, he began to share his interest, and also his anxiety, about sex. He said he thought sex was “gross,” and he began to seem more like an eight year old than a teenager. He began to talk about his affection for animals, criticized a rock star who was publicly cruel to animals, and said, “I'm an animal lover.”

It is clear that Joey had become much more able to tolerate the thoughts, feelings, and vulnerabilities that underlay his presenting problems. In the earliest stage of treatment, his gross defiance was his way of communicating who he was and testing me, and my own actions—setting limits and not taking his bait or responding punitively to his provocations—constituted passing his tests. But each later movement in Joey's opening up and allowing our relationship to become more intimate also seemed hinged on a behavioral test of a pathogenic belief in his relationship with me.[13] He had learned that I would not let myself be mistreated or manipulated by him, but would I let myself be affected by him? How did I feel toward him? Despite his being difficult, would I accept him? Would I appreciate him? How sensitive and self-protective was *I*? How would I respond to his cursing at the answering machine? Would I recognize that he used a different voice when he did this? Would I be interested or punitive when he told me the character's name? When he insulted me affectionately, would I respond to the humor and the affection or the insult? Could I accept his affection and deal with it in a way that felt comfortable to him? How would I respond when he presented his anxieties and his vulnerable side more openly?

My response to these tests, even if I had seen them coming, could not have been preplanned. The interactions were too complex and ambiguous, and they took place largely on an unconscious level for both Joey and me. Only genuine interest and acceptance (these need

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[13] Joey's case can also be seen as an example of the importance of symbolization, for instance, his developing and elaborating his tough-guy stance as a character. This allowed Joey to differentiate a more vulnerable side of himself from this tough aspect and to engage in a more open relationship with me. Conversely, the case of Lisa, the tent girl, which was used to illustrate symbolization, could also have been used to demonstrate the importance of testing the therapist through action. In her case, the test was whether the therapist would respect her aggression and her need for space without intruding, while not becoming detached and distant.

not be complete) could steer me safely through these tests. Using abstinence as a guide would have restricted my range of options in responding to Joey's tests. It would certainly have protected me from certain “failures.” But it would have made me unable to pass, or even to appreciate the meaning of, other tests, especially those in which “passing” required that I struggle with my own discomfort about some of the feelings his behavior evoked in me, about the spot in which he had placed me, and with my own sense of how I should respond. Joey certainly could sense my uneasiness with his provocations, as well as my resolve not to take his bait. Such a struggle communicates the importance the other person has for oneself and one's engagement in the relationship with him. Abstinence would not have been an adequate substitute for responding with spontaneity and authenticity.

The focus in this section has been on patients testing the therapist, but a quieter form of negotiation also takes place continuously in play therapy, and this involves the mutual creation and mutual regulation of the play. As noted, the therapist is not simply an observer but always participates in the therapy, and her behavior inevitably influences the play that evolves. The child, in turn, gives continuous feedback to the therapist based on what the child is trying to discover in the play and on what he can tolerate, and this affects the therapist's way of being with the child. When Jim, my lion boy, became a lion and then I retreated like cornered prey, he smiled. I knew at that moment that I was on the right track, that our unconsciouses were in tune. At other times he simply allowed me to continue what I was doing without discouraging me, as when I changed from a scared animal to a strong, tough one. At still other times, a nuance in Jim's facial expression signaled me to tone down or stop something I was doing, or a shift in his play activity indicated how I should change direction. There is an ongoing negotiation between child and therapist through which the play is created.

The Role of Talking

What is the place of talking in a therapy whose currency is action? With adults much of the renegotiation of self-other relationships takes place through words. But the words are seldom used only, or even

mainly, for their informational value. Words are not alternatives to action, Greenberg (**1996**) says, “They *are* actions…. Words are never neutral; they are our main way of acting on others” (p. 201). The last point is certainly true of adults, although it is *not* generally true of young children, in therapy or out. Children may not be able to move as competently as adults in the world of words, and words may not be so meaningful to them, especially when the going gets tough, but they are quite fluent at communicating through action and at reading others' actions. Words may be essentially a vehicle and an enhancement of the “behavioral dialogue” (**Bakeman and Brown, 1977**, p. 195) that is at the heart of analytic therapy.

What is the place of the therapist's verbal interventions in child therapy? *Labeling* a “character's” feelings, describing the atmosphere of the play, or “sportscasting” the action can capture aspects of a particular experience of the child's. When they do, they *can* be acts of recognition, likely to enhance the child's awareness of a self-state that is just beginning to emerge and foster its greater elaboration in the child's play. They also convey an attitude that values tolerating the communication of difficult aspects of oneself, rather than reacting against them.

A sensitive eight-year-old boy, Paul, is suffering through his parents' stormy marital separation. Each session, he can't wait to play “Sailor Paul.” In this game, we turn a large swivel chair on its back. The chair is a boat. He stands on the chair back as I roll the chair softly this way and that, the “waves” gently rocking the boat back and forth. The day is calm and the sea is flat. Paul is safe. All of a sudden, a hurricane, a tidal wave, an iceberg, lash the boat wildly. He clings to the rails—the chair arms—as the ship heaves and violently tries to throw him off. Miraculously, he's not lost at sea. And then, once again, the day is calm, the sea is quiet, and Paul is secure, knowing that nothing can hurt him. At some point in the many repetitions of this favorite game of Paul's, I begin to describe the situation and label the feelings. “The sea is calm, nothing bad can happen today.” “A quiet relaxing boat ride.” “No reason to worry.” “Oh no, that wave came out of nowhere!” “Can Paul hold on?!” “Will Paul be lost?!” In these sessions, Paul enacted and symbolized a dissociated state—his shock—through play, and the therapist's words helped Paul to further symbolize his experience through the play.

Interpretations, too, can be acts of recognition with children (see **Caspary, 1993**, **pp. 208-209**) and, like the more descriptive verbal interventions discussed earlier, they can also provide a scaffolding that the child may use as she strives to symbolize her experience. But using interpretive comments, even labels, too early may increase the child's anxiety and get in the way of his ability to play. After play has established a relationship in which the child feels known and accepted, he may become more able to talk about his troubles in a meaningful way and to take in what the therapist has to say.

Mutuality in Child Therapy

The issue of mutuality in therapy is closely tied to the idea of the therapeutic relationship as negotiated between the two parties. Lachmann and Beebe's (**1996**) model of therapeutic action, discussed previously, highlights the therapist's active contribution to the patient's behavior and to the course of the therapy. Their model involves *mutual influence and regulation*,[14] both in terms of the ongoing construction of repeated, expectable patterns and as regards the causing of, and response to, disruptions in these mutually created patterns. The *interaction between* patient and therapist is the matrix through which the relationship has therapeutic effect. Among other related terms, they use Bakeman and Brown's (**1977**) phrase “behavioral dialogue” (p. 195) to describe this interaction. This is a successor to Ferenczi's (**1915**) “dialogues of the unconscious” (p. 109).

If “subtle nonverbal behaviors, such as postural and facial interchanges, intonations and tone of voice, and greeting and parting rituals” (**Lachmann and Beebe, 1996**, **p. 4**) are the actions that allow such a strong influence by the therapist in the adult therapeutic relationship, think of the influence a child therapist must exert as he or she gets on the floor and plays with a child! Child therapy contains this key element of therapy in spades.

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[14] Aron (**1996**) distinguishes between mutual regulation and mutual recognition. In my view of child therapy, as with adult psychoanalysis, mutual regulation is a given and mutual recognition is a goal.

Let's examine how child therapists' personalities, expectations, attitudes, and feelings inevitably structure their relationships with their child patients. We can start by asking, Where and how does the analyst set limits? How does he respond when the limits are pushed? What type of play does the therapist *allow*? What type of play does he *understand*? What play does he *like* and *appreciate*? What rubs him the

wrong way? What play materials are offered, and what else in the office may be played with? How does the analyst play? In these ways, the child learns the analyst's native “play language” and learns a lot about the analyst as a person, and these perceptions by the child are likely to determine which self-states the child makes available to the analyst, and when.

Another way to say this is that *the therapist's recognition shapes the child's play*: The child sizes up the therapist and plays in a way that gains him the recognition that is available. As discussed in the section on recognition, even a defiant child engages the therapist by evoking limits, and limits are also a kind of recognition.

Aron and Bushra (as cited in **Aron, 1996**) described how different analysts tend to evoke different states in their patients. I suspect that children, too, play differently with different therapists. For instance, children in my office soon discover that some of my chairs spin and that, although I am happy to spin children around, I quickly get dizzy, so I don't let them spin me very much. They also find that they can turn over the chairs and push them along the floor as cars; they can strip the mattress and pillows off the couch, throw them, or use them to build structures; and they can redo the furniture arrangement in the office. However, I have no sand tray and no water to play with. I have clay, but no one seems to use it. But children in my office do draw a lot and fold paper. I think I tend to become more of a participant in the child's play and less of a commentator as compared with some other child therapists. And although I appreciate a fair degree of wildness, I know that repeated banging on the floor will draw a response from my downstairs neighbor, so I stop if it happens. What does the child learn about me from all this, and how does this shape her experience in therapy?

For contrast: Recently, I spoke with a friend—a gifted child therapist—who uses a “bean tray,” which is a more manageable version of a sand tray. She said that it is very rare, perhaps once or twice a year,

that a child will dump all the beans out of the tray and make a mess with them. I have little doubt that if I had a bean tray, there would be a mess once or twice a week! Also, I know her work well, and I know that she makes very productive use of dolls, puppets, doll houses, and so on—what Erikson (**1940**) called the “microcosmic world.” In my office, though I have these things, children use them much less often. We are usually in a more “macrocosmic world” (**Erikson, 1940**) of dramatic play, with both of us as characters and the therapy room and furniture as props. I am sure she and I could both work well, although perhaps differently, with many children. I also think that there must be some children that one or the other of us would do better with.

A therapist shapes the child's play, but the child shapes the therapist's play, too, through the “unconscious dialogue.” I portrayed one way this happens in my previous discussion of how my play with Jim, the lion boy, was mutually regulated and negotiated between us. From a different perspective, extending the earlier discussion of self-states, self-states are not simply something within the mind of one person; they are interpersonal events. Balint (**1968**), in an early recognition of this fact, described how the strong appeal a patient has for the analyst, which leads the analyst to feel “tempted out of his sympathetic passivity” (p. 21), is “an important diagnostic sign that the work has reached the level of the basic fault” (pp. 19-20). The therapist regresses along with the patient. Aron and Bushra (as cited in **Aron, 1996**) recently discussed mutual regression. Racker (**1968**) described how analysts always identify with their patients in one way or another. The operation of projective identification or something akin to it—the analyst's inner experience reflects something going on in the patient's unconscious—is widely accepted as occurring within analytic relationships (e.g., **Ogden, 1994**). It seems safe to say that the way the analyst plays with the child is strongly influenced by the child and that the mood of the play is created by both patient and analyst.

When our dissociated states emerge in play, we are playing with our own subjectivity, but social play also is a way of playing with someone else's subjectivity. Self-states involve a whole perceptual experience, including an experience of ourselves and of the other with whom we are in some relation. When we play with another person, we are looking for, and evoking, certain states in that other person, not only states in ourselves. We can be fascinated by those states in others and

by shifts involving these states, which are problematic and disturbing for us. For instance, children's play often finds pleasure in the other's anger and power.

Play with others also involves the interplay of our *fantasies* of others, which we try to impose on them, and their *actuality*, which both resists and enriches our fantasies. The child who tries to provoke the other's anger may find that concern or kindness tempers the other's reaction, and this may influence the child's subsequent fantasies (see the previous section on renegotiating self-other relationships).

Vygotsky's (**1933**, p. 546) concept of the “pivot” may apply here. In play, the pivot is the object that fosters the leap into imagination—for instance, the broomstick that becomes a horse. Does the other's subjectivity serve a related function in social play? The other person's simple presence may help us pivot into imagination. His subjectivity lets us pivot into an enriched fantasy life that communicates more freely with the actual interpersonal world and engages it more openly.

Illustrative Session

Here is a session that illustrates both patient and therapist playing from our unconsciouses. Some of the meaning of the play is clear, but it is largely ambiguous. Yet it is clearly *important play*, with a strong sense of something growing, and of connection, communication and mutuality. I can't say exactly why I responded as I did, when I did, but I did and do have the sense that my response was crucial to the evolution of the play and that the play evolved in a way that evoked, expressed, and articulated disavowed aspects of this seven-year-old boy's inner experience.

Roy comes in and asks, “Can we play the fighting game?” He used to be anxious, tentative, babyish, and withdrawn with me, as he was with other children and in school. I used to feel more disengaged from him than I do now. He is much less tentative with me than he used to be, though he still sometimes feels he needs to ask if he can do something. “Sure,” I say. “You're my twin,” he says. “And my enemy.” We're characters in a combat video game. He tells me to kick him. I make kicking motions at him, and he evades them. Then we add pillows to the fight. As I swing at him with pillows, he shows me a scared look, as if to let

me know that he is the victim and I am to beat him. He becomes more excited. Then he becomes the beater, and then the victim again.

Next, he sits in the revolving chair and says, whimsically, regally, “Spin me, Rasputin!” He seems utterly relaxed, not at all self-conscious. He has a towel, and he hits me with it every time the chair comes around and says that I should hit him with a pillow every time he hits me. I do, but sometimes I hit him when he doesn't hit me. He protests, and smiles, when this happens. He stops and demands “Ice, slave!” and when I give him ice from the freezer, he throws a few chips of ice at me. Then I am to beat him again with pillows.

I say, “This is a bully game, and right now I'm the bully.” He dramatizes the scared look on his face again, mixed with a look that shows pleasure and also indicates that my statement is correct (an example, by the way, of his negotiating with me to influence my response to him). The roles switch often, and I certainly get emotionally involved with whatever role I am playing at the moment. When I feel I need a break (it is a physically tiring game), we simply stop the game for a minute. There is a sense of real connection through our battles and our breaks.

After a while, he becomes a composite animal, at first mainly a rabbit and later a monkey. I choose to be a pig. We continue to battle as these animals, with sound effects and dramatics and with much pleasure and, using pillows, with some force.

Earlier in therapy, when Roy was more anxious and guarded, I was more cautious with him. I tried gently and carefully to create a space where he could feel safe. That was achieved. In the current session, as I play with him, I am mostly like another kid engaged in the play, not parental, posed, or calculated. I play from my strong but unformulated sense of connection to him and to the game, from my sense of who he is, and from my own pleasure in our play, which includes my own (closely monitored) sadism. There are indications that this is the right game and that it is evolving correctly—in Bromberg's (**1994**) words, that Roy's “dissociated domains of self … [are] achiev[ing] symbolization… through enactment in a relational context” (p. 535).

My experience with Roy at this point is of a relaxed, energized, and mutually creative interaction. Things go where they will without my worrying much about his anxieties or sensitivities (although I am sure I would respond to them if they announced themselves). New self-states

from each of us, including regressive ones, find their way easily into the play. Each self-state that is expressed by either of us is highly responsive to self-states in the other. The emergence and articulation of self-states in each of us is constantly regulated by both of us in a continuous, nonverbal process of negotiation. Our regressions are mutual, and the pace at which they evolve is mutually regulated.

The therapist's willingness to regress along with the child—to let new and surprising areas of himself into the play—and especially his willingness and ability to let the child largely control the pace and content

of their mutual regression, help the child feel safe to open up new areas of herself to the therapist. The particular aspects of himself that the therapist brings to the play are used by the child as a pivot to help the child engage new areas of herself. Mutual recognition, mutual responsiveness, creative negotiation, and self-discovery are all inherent in this interaction, and each of these concepts implies the others.

I could put words to some of what I suspect Roy is playing out: the fantasies that absorb him when he is alone; his working over problematic relationships with other children, from whom he used to keep himself withdrawn and where he now is sometimes on both ends of bullying; and his experience of his family life, where his parents' relationship to each other and to him is loving but in some ways also difficult. I can understand his play as a demonstration of the sadistic and masochistic solutions he has come up with and also of his transcendence of these collusive strategies by playing with them in what has become an intimate relationship between us. These thoughts do guide me, although largely on a preconscious level. But they feel like speculations, afterthoughts. In the moment of playing with him, I trust my feelings of concern and connection to him and my strong sense of the inner, unarticulated logic of our play. I also trust his wish and ability to make himself known to me. These beliefs underpin my confidence in the interrelatedness of our self-states and in my responsiveness to his corrective feedback, so I let myself play without calculation.

Recognizing the central role of mutuality in child therapy is important and relevant not only because it corrects a long-standing misperception of child therapy, but because an interpersonal relationship in which intersubjectivity (i.e., mutual recognition) is valued defines the kind of relationship in which play is most likely to flourish and in which

ongoing negotiations between patient and therapist have latitude to evolve most productively. This kind of relationship, therefore, may be inherently therapeutic (see **Frankel, 1993**).

Where does this take us in our thinking about our adult patients? When we play with children and when we work out our relationship with them with an attitude of perspective and mutuality and in a playful spirit, they seem able to find in the therapy what they need to grow. Can we do the same with adults? Perhaps we can help our adult treatments become play therapy, too.

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