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Unlocking the Family Secret in Family Play Therapy

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ABSTRACT: Family play therapy combines play therapy with family systems therapy. When family secrets are revealed in a family setting, with play to cushion the family's anxiety, families have the opportunity to resolve long-standing intrapsychic and interpersonal difficulties that impede the psychological well-being of both children and parents. Family play therapy effectively reduces symptomatic behavior in children in an age-appropriate manner—an advantage over family therapy that may be geared to adult cognitive levels. It also gradually shifts the family to a systems perspective of its problems in a non-threatening way, thereby facilitating the child's connection to his or her primary caretakers.

Introduction

The dramatic effect of catharsis in Greek tragedy (indeed, in modern drama as well) often relied upon the revelation of a family secret that—once discovered—served to bring about the destruction of the principal characters. So, for example, when the secret of Oedipus' parentage becomes common knowledge, he inflicts blindness on himself, his wife-mother commits suicide, and his children inherit the "sins of the father."

In play therapy, a clinician may be the first outside audience for a family drama in which the young client is a primary actor. The story a child weaves in the context of a play session is a valuable tool for gaining insight into the intrapsychic functioning of the child, illuminates family dynamics, and often exposes information the family would prefer to keep secret from the outside world or from each other. These "secrets" often have a substantial influence on the psychological functioning (or dysfunctioning) of all family members, including the symptomatic child (Pincus & Dare, 1978).

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Traditionally, play therapy has been viewed as child psychoanalysis. It is the thesis of this paper, however, that play therapy can be successfully adapted as a technique with family groups, and that, far from being destructive, unlocking secrets in a family context promotes both individual and family growth. Family play therapy combines play therapy techniques with family systems therapy and offers the benefits of each. It effectively reduces symptomatic behavior in the identified patient in an age-appropriate manner, as it gradually shifts the family to a systems view of its problems in a non-threatening way.

The atmosphere of play cushions the family's anxieties about revealing its secrets, while the presence of family in the treatment session fosters the relationship system that is so critical to the child's psychological well-being (Fogarty, 1979).

The discussion will include: the function of the family secret, an overview of various models of family therapy, a rationale for family play therapy, assessment and intervention in family play therapy, and a discussion of the problems inherent in treating children and their families with this approach.

The Family Secret

Pincus and Dare (1978) suggest two types of family secrets, those based on actual events and those arising from fantasy. The first category includes events or circumstances that one or several members attempt to hide either from each other, or those that all family members collude in hiding from non-family members. These would encompass affairs, marital difficulties, money problems, severe illness, alcoholism, drug abuse, suicides, illegitimate births, etc. While parents commonly shelter children from potentially disturbing information, Pincus and Dare (1978) note that children often exhibit an unconscious awareness of such problems in their acting out behavior. They cite the case of a woman who had a third child out-of-wedlock following her husband's death, unbeknownst to anyone, including her three daughters. Years later, her eldest daughter repeated the pattern.

Mary Woods (1982) wrote about a young girl's snake phobia, which the therapist suspected was related to her mother's ill-health. Neither parent had discussed the mother's pending death with the therapist, the child or the grandparents. After exploring the mother's illness in a session, Woods notes that once the secret was revealed, communication between family members became more open to a fuller expression of feelings by both parents and child. The girl's phobia abated, and the family went on to work through the grieving process.

Although he did not elaborate on this material, Freud (1913) suggested that there seemed to be an unconscious transmission of psychic information from one generation to the next. This process, which Bowen (1978) terms the inter-generational transmission process, may account for the uncanny duplication of parental patterns of dysfunction by their offspring, as well as the inexplicable awareness that children often display regarding parental problems.

Karpel (1980) points out that the key issue in family secrets is awareness—"who knows," and "who doesn't know," as well as "who knows that so-and-so does or does not also know." Alliances and boundaries in the family are formulated on the basis of knowledge about the secret, that has the effect of isolating members from each other. The therapist can be brought into such relationship systems in a variety of ways that can compromise the validity of therapy (e.g., by being entrusted with a secret by one family member, or participating in the family's denial of the importance of certain information known equally by all of them but withheld from the therapist). Families with alcoholic members often fall in the latter case, and therapists can find it extremely difficult to generate movement until the reality of the alcohol problem is acknowledged.

The second type of family secret, what Pincus and Dare (1978) refer to as fantasies, Ferreira (1962) called family myths. According to Ferreira, myths serve the same function for the family as the defense does for the individual. Generally operating outside of conscious awareness and rarely articulated, myths reflect attitudes and beliefs shared by all family members, such as, "the family would have been fine if not for so-and-so" or "we have no problems." They create a family fiction that protects family members from pain and becomes essential to family survival. When parents bring a child for therapy, they may be attempting to hide the secret by focusing on the child's problems (Guerin & Gordon, 1983). Generally there is considerable resistance on the part of parents to working on surrounding issues. It is often easier to blame the family discomfort on a child, and in some cases to seek a divorce, than to confront the myth. The child's "problem" serves as a diversion, and the family colludes to protect its integrity and maintain the family secret, albeit at the expense of the child's developmental progress.

Problems seem more likely to surface in response to certain nodal events or transition periods in the family associated with the child's natural developmental stages (Ferreira, 1963). Pincus and Dare (1978) relate the child's apparent difficulty in accomplishing the psychological tasks of a new stage to the parents being fixated at a similar stage of intrapsychic development, while Carter and McGoldrick (1980) suggest a family systems paradigm for the same phenomenon.

Individual temperament and the family projection process combine to

make a particular child vulnerable to being seen as "the identified patient" by the family. Thomas, Chess and Birch (1968) described nine distinct behavioral characteristics of infants, and three constellations of temperament in an effort to predict future behavior problems. They postulated that the "difficult child" was more likely to exhibit symptomatic behavior at a later date. The projection process takes into account birth order; gender; events surrounding conception and birth; the past and present orientation of the parents to the marriage; as well as the parental, especially maternal, reaction to a particular child that can be traced to the child's real or imagined resemblance to other family members, especially grandparents and the spouse (Bowen, 1978).

Child analysts typically referred parents for their own analysis when there seemed to be extenuating parental pathology influencing the patient. Aside from the transferential issues of treating children with their parents, it was thought that the revelation of certain material in a family session would be too anxiety-provoking for all concerned, and perhaps lead to repurcussions that would endanger the child at home. However, Pincus and Dare write: "It is interesting that whenever a family member is able to challenge a family secret, then the attitude of other family members towards the secret also seems to change; the collusive system is broken and new facts and fantasies come into the open" (1978, p. 11).

The following case illustrates how the initial revelation of a family secret by a symptomatic child in a family play therapy session often begins a chain-reaction, whereby other family members feel free to reveal their own secrets.

John, ten, was referred to therapy, for emotional problems surrounding his asthma, by his pediatrician following a life-threatening attack for which he had been hospitalized. During the hospitalization, the boy saw his father, David, for the first time at length in several years. David, now remarried, had seen John and his brother Robert, twelve, irregularly over the past seven years due to his ex-wife's repeated interference. During the hospitalization, David, already a client with his second wife and her children, was encouraged to establish appointments for visitations directly with John, and did so. David brought John for his first session. In the course of play therapy with his father, John spoke about a little boy who wanted his father to come home and be with his mother. With some interpretation, the child readily made a connection between his symptoms and his "secret plan" to bring his father home. This secret plan isolated John from his entire family, and was a tremendous burden for a small child. In a subsequent session, John and David were joined by the mother, Clare, and Robert. Notably, this was the first time David had actually seen Clare since the divorce, as he never entered the family apartment on his infrequent visits with the children. Family play therapy from this point on also addressed Robert's school problems, and his rage at his mother. Clare was able to admit that she still loved David and had not resolved the divorce (much to David's surprise), and relate these secret

feelings to her preference for John, who resembled her, and her difficulties with Robert, who resembled his father. John again expressed his wish that the father "come home," however, he was able to suggest his own version of a compromise—"Mommy and Daddy could be friends." Shortly after the family's "reunion" in therapy, John's asthmatic symptoms abated. Additional work was done with Robert, whose behavior at home and school temporarily worsened. However, the work was done under the guise of helping his younger brother in order to overcome adolescent resistance to work with the family.

Family play therapy led these parents to resolve their divorce and establish a more cooperative co-parental agreement. Thus, while families may be resistant to exposing their secrets, they seem to gain from careful and purposeful assistance in bringing these issues into the open.

Family Therapy

Child psychiatry has long recognized the role a child's environment plays in symptomatic behavior (Haworth, 1964). Klein (1981) writes that with her first case, she initially worked with just the mother, and only later chose to focus primarily on the child. Brinich (1984) reports on a case where a girl's aggressive tendencies were successfully treated in joint sessions with the mother, who also exhibited difficulty with aggression. Anthony (1980) suggests that work with families is a logical step from child analysis. He writes: "One has developed the habit of negotiating with the parents, but one could as well deal with the family and at least help to dissipate some of its paralyzing secrets" (1980, p. 16).

This view is reflected in the increasing practice of including parents in the treatment of their children by therapists of varying orientations. Umana, et al. (1980) described three basic family therapy models: psychoanalytic, behavioral, and family systems.

Psychoanalytic family therapy assumes that family pathology is based on the failure of parents to successfully individuate and complete developmental tasks. Pincus and Dare (1978) view family secrets in a developmental context based on analytic concerns. The child's developmental problem becomes the catalyst for the parents to resolve their own ego-oriented issues.

Behavioral family therapists share the basic assumptions of behavioral therapy, seeing the family as a primary system of rewards and punishments. They propose that behavior can be changed by manipulating the stimulus and/or response of family members involved. In this context, the behavioral family therapist works with the parents so that they become more effective reinforcers for the child, and both parents and children

learn more mutually desirable behaviors. Guerney, et al. (1964; 1981) used play therapy techniques in what they term "filial therapy" for this purpose.

Family systems therapy focuses on changing rigid circular patterns of communication that have become dysfunctional, as evidenced by the negative behavior of the identified patient (Haley, 1963). This assumes that the problem resides in all family members, and is based on the fact that when a child becomes asymptomatic, problems frequently appear in another sibling or in the marriage. A primary tenet of this model is that the family seeks first to maintain equilibrium, or homeostasis (Jackson, 1968). This balance is perpetuated by a series of interlocking triangles (Bowen, 1971). Bowen postulates that in a family with a high level of dysfunction, the family members are highly reactive to, or fused with, one another in an "undifferentiated ego mass." Children tend to become mere extensions of parents in such families, and prone to act out their feelings. For example, in the case cited earlier, John was fused with the mother and acting out her position around the divorce, while Robert was fused with his father, and mirroring his hostile feelings towards the ex-wife.

All three approaches share concerns about the ultimate effectiveness of child therapy that does not include an attempt to reshape the family environment. In addition, they also see value in exposing previously hidden messages within the family context, and attempt to shift the focus in some way to the parents' functioning in marital, parental, and in some cases, filial roles.

A Rationale for Family Play Therapy

Family play therapy integrates play therapy techniques with a systemic approach to families where the child is the identified patient, and defers transferential issues away from the therapist and onto family members. This is done to facilitate the child's connection to the family and avoid the development of an attachment to the therapist who must someday terminate the relationship. Certainly, there are cases where a child from a seriously disturbed family could benefit from a new connection to a "good-parent image" (Moustakas, 1964). For example, West (1983) developed such a connection to the 6-year-old daughter of a mother imprisoned for prostitution. However, Fogarty (1979) suggests that "any time a therapist becomes more important to the child than the family the therapist is doing a disservice to the child" (1979, p. 6). This is reinforced by Bowen's (1978) emphasis on the importance of children learning to cope with their

reactivity to their parents in a positive way. He writes: "Connecting with his parents and siblings, the child develops one-on-one relationships with his family and this prepares the child for every rejection, resistance or alliance present everywhere in his life" (1979, p. 368).

In family play therapy, the child sees himself as more worthwhile in the context of a family situation. Both children and their parents learn to cope with their mutual reactivity in a positive way. Although most people enter therapy, or seek therapy for their children, when a bad situation begins to look hopeless, play reintroduces an element of humor into a family that may be experiencing severe stress. Humor is a common technique in traditional family therapy, and is in a sense a form of play—a play of ideas. Eckstein (1976) describes the need to play with thoughts in therapy, using the German word "Spielraum," meaning "elbow-room." He suggests that a sense of play is what creates the space whereby a problem can be thought out and solutions found. This can be as true for families as it is for children and adults in individual therapy. Therapists who work successfully with children in play may already have a significant head start on introducing play into their work with adults. By introducing play as a medium into the family session, the therapist can illustrate the need for balance between work and play in family life, something that parents can easily forget under the multiple pressures of careers and children.

Family members are not protected from each other, however; the therapist stays with the family's definition of the problem until the family appears ready to face the child's symptom as the family problem. Admittedly, the difficulty for the therapist here is in the transition period during which the family becomes aware, through the child's play, that the problem is shared by other family members. How and when secrets emerge is similar to delicate surgery, and the therapist must generate an atmosphere of acceptance that deems this shift helpful by all concerned.

With the emergence of the family secret, parents may begin to see the connection between the child's symptoms and the family problem. The therapist acts as a role model, cushioning the child and family as they become more aware of underlying problems. Naturally when the child starts to change, this upsets the family's homeostasis, and parental anxiety may escalate. At this juncture, family play therapy offers an advantage over traditional play therapy. Rather than referring parents to another therapist, their reactions to the changes in the child are dealt with directly and the part each plays in maintaining the homeostasis of the family is revealed. This eliminates the confusion that can develop from the family's contact with more than one therapist and treatment modality (Braverman, et al., 1984).

Family play therapy capitalizes on the heavy emotional investments most parents—despite their own personal psychological limitations—have in their children. It assumes a willingness on the part of parents to participate in the treatment of their child, however this method has proved especially valuable in empowering resistant families where parental alcohol and substance abuse are underlying problems in the child's symptoms. Vaillant (1977) points out that true alcoholics and drug addicts are not considered analyzable because the biochemical and psychophysiological changes caused by the addiction dissipate the optimal amount of anxiety required to do psychotherapy. Even after detoxification, the recovering parent may tend to be absorbed in maintaining sobriety and over focused on this to the exclusion of family matters. Family play therapy offers the potential to re-establish a positive connection between parents and children who may be badly scarred by years of living within a family system balanced by alcohol or drugs (Stanton, et al., 1982). In particular, problems in relating to others spontaneously on a feeling level, long masked by the reliance on alcohol or drugs, can be dealt with effectively in family play therapy.

The following case provides an illustration of how play therapy was used in a family where the father's alcoholism was an undeclared problem in the therapy (i.e. a family "secret" from the therapist) but a major factor in a child's school phobia.

Mr. and Mrs. Linder had been in marital therapy for several years. Both had a long history of individual treatment, including analysis, yet at this point the father was often unemployed. Mr. Linder's "drinking" was casually mentioned by Mrs. Linder as "somewhat of a problem." In the course of therapy, both spouses developed an almost expert awareness of the dynamics in both families of origin. Sessions consisted of lively and intelligent discussions of problems that persisted despite therapy.

Finally Mrs. Linder reported that Charles, five, now refused to attend school. Since the school-phobia indicated difficulty separating from mother, I requested that Mr. Linder bring Charles for treatment. In the first session, Charles showed a little boy figure "at home" with his mother crying and his father sleeping when he was "supposed to be at work." He then portrayed the parent figures fighting, while the "sad, little boy" watched helplessly. Moving the little boy to "school" he showed him getting in fights. Charles did not have this problem, but exhibited a precocious awareness of his older brother's problem, briefly treated a few years before.

In the second session, I requested that the brother, Tom, thirteen, come to "help Charles with his problem." Father and brother joined Charles on the floor with the house and figures. Tom encouraged the little boy figure by saying that school was fun, and assuring him that mother would be all right. Then Mr. Linder took the part of another little boy, and showed him at home looking for his mother. He revealed a level of sadness never expressed in all his frank discussions of his childhood. Both sons witnessed their father's vulnerability, as he explained that

his mother had abandoned him as a child, first through drinking, and later by actually leaving when, he, too, was five years old.

This session precipitated Mr. Linder's admission of the severity of his drinking and he joined AA. A three-generational perspective helped his sons, especially Tom, to gain an understanding of their father and to lower their expectations of him to a more realistic level. Attention to the alcoholism reduced symptoms in both children, and enabled Mr. and Mrs. Linder to achieve some long-awaited positive movement in their marriage.

Family play therapy offers advantages over traditional family therapy. Very young children have limited experience with language and may not understand the dynamics in a traditional family session. Frequently, they may get bored in conversations geared towards adult cognitive levels. Parents and therapists alike may fail to take into account the child's magical thinking when discussing problems. Family play therapy provides the opportunity for the parent to see in the child's symbolic play how the child feels about the family and the parent. For children who are already verbal, play therapy encourages talking even more than play.

Play also has the effect of creating enough emotional distance between family members for the truth to be spoken. The child might otherwise be incapable of expressing feelings openly to the parent due to the threatening emotional content. The child's attention to the play materials in a sense duplicates the "couch" by allowing the child to free associate and communicate with child-like freedom. Far from inhibiting expression as one might think, children seem to trust the parent, as well as the therapist, when both enter into the world of play. By the same token, without play as a buffer, the parent might be less able to accept the child's feelings.

Just as play assists the child in expressing feelings because it is non-confrontational, it is also effective with the parent or adolescent who has difficulty verbalizing feelings. It helps to uncover fears and anxiety operating unconsciously by eliciting an emotional memory of the parent's childhood. For example, Mr. Linder who was prone to intellectualize his problems, was able to unlock the "secret" of his mother's abandonment and get in touch with the sadness underneath his drinking problem. Thus, in addition to creating greater empathy with the child, by bringing the parents into the play situation, the therapist can also assist them in recreating the childhood relationships with their own parents. Even when the grandparents are unavailable for treatment sessions, this establishes a three-generational approach to the problem that greatly reduces judgment and blame of any individual family member. As seen in the previous case discussions, family play therapy can facilitate the participation of an adolescent under the guise of helping a younger sibling

with a problem. It also provides the therapist with an opportunity to observe and interpret parent-child interactions in a way that is more immediate than merely listening to the parent's reports about incidents that have occurred at home.

Play serves as a cushion in sustaining resistant families in treatment. Many families drop out after secrets emerge in standard family therapy, yet as Winnicott (1980) points out, even when anxiety-provoking, play is a satisfying and non-threatening experience. Interspersed with discussion, it can be used to ameliorate the family's anxiety when it escalates during different points in the session. Both children and parents can retreat into play when the core problem or secret begins to surface and they are not ready to deal with it.

Instead of viewing the child as a traitor, the parent has an opportunity to understand the child's feelings as well as to see the child's symptoms as an effort to help the family. Through this process the child's symptomatic behavior begins to seem like a healthy reaction to an unhealthy situation (Woods, 1982). Rather than suffering the low self-esteem common to children with behavioral problems, the child gets the sense of having created an opening for the parents to resolve their own intrapsychic and interpersonal issues in a therapeutic milieu. By bringing family secrets into the open, family play therapy, initiated with the goal of alleviating the child's symptoms, becomes a catalyst for a deeper inquiry into the family's shared problem.

Additionally, traditional modes of therapy are expensive and time-consuming (Hobbs, 1963), and not uniformly available to all socio-economic groups, thus making innovative approaches to treatment a necessity. Straughan (1981), a behavioral play therapist, suggests that having the mother in the play room would shorten treatment, and both Guerney (1964; 1981) and Ginsberg (1976) found that "filial play therapy" maximized staff resources in mental health clinics. Family play therapy addresses these concerns and also incorporates elements of psychoeducation, which Anderson (1983) suggests may be critical in treating and/or preventing mental illness. By teaching parents to interact with their child on an ongoing basis in the way the child feels most comfortable, family play therapy may prevent future problems (Guerney 1964; 1981).

Assessment and Intervention

In family play therapy, intervention and assessment start simultaneously. In the first session, one or both parents, depending on the circumstances, arrive with the child. When there are two parents, both are

requested to attend, however, in single-parent situations, it is not necessary and may be undesireable (Herz, in print) to bring in an ex-spouse for the first meeting. If the family is relatively small, siblings may be included as well during the first interview. Subsequent meetings can be scheduled with varying constellations of family members, including individual sessions, however, it is critical that the child be seen with the parents during the initial sessions to establish the basic premise of family treatment.

The parents generally proceed to give a litany of their difficulties with the identified patient. The child is allowed to play nearby in a non-structured way as the parents give the history. The focus of the first interview is to take the pressure off the identified patient, and to educate the family to some of the basic principles of family systems thinking. The concept of triangles, as well as pursuer and distancer, are explained, and this breaks down the barrier of professional secrecy between therapist and family.

Ground rules are also established. It is stressed that the child must be allowed full expression of feelings, without fear of reprisal at home. The therapist tells both child and parents that secrets are not necessary, and establishes an open atmosphere. Making this contract with the parents in full view of the child lets the child know that both parent and child can feel protected by the therapist.

Initially, one prepares the child to express feelings freely and explains to the family that play is the natural way that children share their concerns and pain. It is important for both the therapist and the parents to understand that the play reflects the child's truth, though not necessarily the family's. The goal is to create an atmosphere where the child can play freely and verbalize without judgement or blame.

While the therapist will generally stay with the parental definition of the problem, the parents gradually learn that they have a part in maintaining the problem. The therapist also "warns" the parents that when this child's problem improves, they may experience other problems in the family, so they should not be alarmed when the symptom shifts. They are also told that different family members may react differently (relief, anger) to the information the child presents, and that this, too, is part of the process.

As the therapist sets the ground rules and takes a family history, the child naturally listens to the parents while playing and takes in their impressions. The therapist then includes the child in an age-appropriate way. The taking of the genogram, for example, can be accomplished by asking the child to draw a "family tree" and fill in the names and faces of relatives and, even pets and favorite toys. Even the very young child can

grasp the concept of triangles when the therapist draws them on the genogram to show the family's relationship system. This process may take more than one session.

It should be noted that pets and toys can be particularly useful in bringing out a child's "secrets." One young girl treated in a clinic setting only revealed a history of incest in a symbolic discussion about the family dog's being afraid of her father. Another non-verbal youngster became very verbal when he brought his hamster and clarinet to a session. Lieberman (1979) suggests that it may be useful for a child to bring pets and friends into a session. This acknowledges the child's connection to these love-objects and assists in creating an atmosphere of acceptance for the child.

Another way to bring the child into the discussion is to ask the child to tell the therapist about the parents. This has the effect of reversing roles with parents who are generally the only ones asked to participate in this way. Questions, such as "What does Daddy do?" "What does Mommy like?" "What do you like best about Mommy?" "Are you like Daddy in any way?" can be accompanied by the child drawing a picture of the parents. The child will usually share the negatives readily, and the therapist can then shift the conversation in a more positive direction by asking the child to fantasize about what the parent was like as a child.

During the session, parents are asked to remain attentive to their child, and are engaged in the play process. No criticism of the child is allowed. Should the child make new rules for games (e.g., Monopoly), the parent is instructed to go along with them. The parent is also coached to provide interpretations to the child based on the play behavior. These are to be neutral comments that demonstrate acceptance of the child by merely noting aloud what the child seems to be feeling (e.g., "It makes you mad when I don't answer you right away").

Sometimes a child will verbally cooperate while refusing to play. The therapist can attempt to initiate the play if the child is reluctant, with suggestions like, "now we'll do this together," or "how would you like to do such and such?" If the child becomes very anxious and puts the play material down, the therapist can introduce it later when it is less anxiety-provoking.

The therapist is a participant in the play as well as an observer and objective interpreter. The parents' participation in the play minimizes the focus on the child and deals with the family projection process that has led to the child-focused definition of the problem; however the therapist needs to take an active role to direct the movement. If two parents are present, the most distant one is asked to play directly with the child, and instructed to continue play sessions daily for ten minutes at home. As Haworth (1964) has noted: "What happens to the child outside the thera-

pist's office, e.g., the child's social interactions at home and in the community may be even more important than what transpires between child and therapist in the therapy hour" (1964, p. 10). Assigning "homework" fosters positive connectedness between parent and child, as at this point, therapy may be the only concrete, positive relationship time the parent spends with the child.

Throughout this process, the therapist interprets the child's reaction for the parents and the child. Klein (1981) emphasized that it is a simple interpretation that leads the child to insight and understanding, and stated that this is the key to effective play therapy. In family play therapy, the therapist re-labels "bad behavior" as a cry for help, so that the parents do not feel so helpless and negative towards the child. When the therapist can interpret the child's actions with the parents present, the parents can begin to understand their child, and the child in themselves as well.

It is generally wise to allow free play in the initial sessions. However, once the therapist has a sense of the presenting problem, structured play techniques can quickly replace nonstructured approaches to ascertain the validity of the therapist's hypothesis. With any family, there is always a question as to how long they will remain in treatment, and it is critical to work in the most expedient manner possible. Structured play is well suited to the release and mastery of repressed material, although many play therapists do not use it when the child makes adequate progress with spontaneous play or verbal interaction (Hambridge, 1981).

In family play therapy, structured play provides an excellent medium and technique for focusing on the presenting problem. The therapist recreates in dramatic play an event, situation, or conflict suspected of precipitating or maintaining the child's symptoms, so as to test hypotheses about the nature of the problem. Structured play eliminates waiting for material, especially where toxic issues, such as school, parent-child relationships, and marital issues are concerned, and may serve to cool the system down by bringing the issues into the the open with an impartial observer listening. Innumerable conflict situations, as they present themselves either in the history or other sources of data about the child, can be set up by the therapist in dramatic form for play therapy with family participation. The therapist observes the play for content and form, the verbal and nonverbal disruptions of the play, as well as gestures between various family members.

There are many kinds of play materials that can facilitate a structured play situation. For children ages three to eleven, dolls, play houses, family figures, play furniture, clay, crayons, paints, Lincoln Logs, building blocks, darts, punching bags, cobbler bench with wooden hammer and nails, have all been used effectively with the parent being instructed to

play with the child. The selection of appropriate materials requires considerable knowledge of developmental needs, as well as an understanding of how certain types of children interact with specific materials (Lieberman, 1979).

Puppets can be used to ad lib plays and stories, and offer family, child and therapist opportunities to communicate. For older children, games such as checkers and Monopoly can be suitable. The Gilligan's Island Game has also proved valuable.

In addition to structuring materials for use with families, mutual storytelling has been especially valuable for family work (Gardner, 1981). In mutual storytelling, the child tells a story, prompted if necessary by the therapist, after which the therapist retells the story, offering alternative endings or morals to the child's tale.

Family play therapy utilizes the technique both with and without play materials. Parents are coached to tell their own stories, join in the storytelling with the child, or to present alternative endings to the child. Generally, the child starts the story and other family members are encouraged to make contributions spontaneously. However, some children may have difficulty starting a tale, and in such cases the parent or the therapist may begin. The therapist may also ask questions, or make additions to the storyline in order to facilitate the exercise.

The technique has been especially valuable in sessions where family secrets are revealed, as the new moral provides an alternative way of thinking about the firmly held family myth. In the following case, mutual storytelling was used in combination with the Gilligan's Island Game, with a father and two of his seven children.

Richard's wife had asked him for a divorce. Still living in the marital home, he came into therapy saying that he feared he would not have any relationship with the children because of his wife's hostility towards him. This was a most realistic fear as the father rarely spoke with his children while living in the house, as the mother had ostracized him from the family's daily activities. He spoke of his feeling of isolation in an individual session, and I suggested that the Gilligan's Island Game might help the children understand his predicament. Jaimie, ten, and Molly, eight, joined their father for several sessions. At this session, I used mutual storytelling to bring some closure to a previous discussion of the family secret—a single-act of violence Richard had committed against his wife during the marital crisis, for which she had called the police.

Jaimie: The father's out there on the island.
Therapist: Does he like it out there?
Jaimie: Nah, nobody likes him.
Molly: A coconut fell on his head.
Father: He's hurt.
Jaimie: So who cares?
Molly: I care. He might be dead, I don't know.

Therapist: Where's everybody else?
Jaimie: The boy and girl are over here in a house. So's the mother. She won't let them help the father.
Therapist: Why not?
Jaimie: He did a real bad thing and he has to be punished. The policeman put him on the island.
Therapist: The island is the father's jail?
Jaimie: Yeah.
Father: People get visitors in jail.
Molly: The girl could bring him food and water.
Father: The father would like that. (His voice cracks; father becomes visibly upset.)
Therapist: What would the mother do if the girl brought the father food and water?
Molly: She'd be very mad. Maybe kick her onto the island, too. But the girl doesn't care.
Jaimie: The little boy and the little girl can't get to the island anyway. They can't drive the boat.

The Gilligan's Island Game was a perfect metaphor for this father's feelings about his relationship to his family. After Jaime's last remark, Richard broke down and cried, apologizing profusely for hitting their mother. The children were able to see their father's feelings, and I took this opportunity to suggest that even when people do bad things, they do not have to be punished forever. I suggested that forgiving people for the bad things that they do was also important. Each child felt safe expressing either a cavalier attitude towards their father ("So who cares?") or concern ("The girl could bring him food and water.") Molly was open about her affection for her father, and admitted that she was the little girl in the story. Sensing Jaimie's fear that he had no power to maintain contact ("They can't drive the boat"), I suggested that the father could be happy on the island because there was a nice beach and friendly animals, and that he could drive the boat to the house and get the children so that they could enjoy the island with him. I then told Jaimie to ask his mother's permission in the game to love and visit his father. Jaimie did so, and playing the role of mother, I gave him my permission. He was then instructed to repeat his request to his mother at home. He did so and gained her permission to continue contact with his father.

In this case, there had been a family secret, known to Richard, the wife, and the two older children that threatened to create further distance between the father and children, not because of a lack of awareness, but because of the taboo about discussing it. Opening up this subject as well as discussing the other aspects of the divorce decreased the intensity of an emerging triangle between Richard, his wife, and their children. This case also illustrates the value of working with children, who are typically less well defended than their parents, in an effort to relieve the anxiety in a family system that is attempting to repress certain closely held information. In the safety of the play situation, Molly easily realized that *she* was the "little girl" in the story without prompting from the adults present. Jaimie expressed a child's typical ambivalence about his ability to

love both parents, and was able to find value in Molly's different response to the issue of loyalty. Although mother had been attempting to sabotage the therapy, she, too, was indirectly included in the treatment and responded positively to Jaime's direct expression of concern for his father. Richard, who had been reluctant to leave the marital home despite his wife's demands to do so, was enabled to separate and subsequently establish positive relationships with Jaimie, Molly, and one older sibling. One might assume in the future that the younger siblings will be encouraged by these three to connect with their father.

Problems in Family Play Therapy

Family play therapy is a valuable technique, however, it is not for use by every therapist, nor should it be used indiscriminately in every case. One must already have a knowledge of the appropriateness of the various materials and methods of play therapy, as well as skill in working with family groups.

In any treatment modality, it is essential that the role of the therapist be clearly defined so that the therapist can feel comfortable in its use. A therapist accustomed to traditional play therapy may experience discomfort doing play therapy in the presence of the parents. Admittedly, play therapy itself is difficult to do properly, and may be complicated by the presence of an adult. The therapist must learn to listen with a "third ear" (Lieberman, 1986) to the communications of both generations. Schaefer (1981) writes of an unusual case in which the mother was present in the play therapy. Her presence added complexity to the therapeutic situation as it required constant unobtrusive interpretations to the mother and reassurances regarding the most severe manifestations of the child's behavior.

Shifting one's perceptions from an intrapsychic view to seeing the problems as a metaphor of the family problem, will actually assist the therapist in feeling more comfortable with including the parents. De-emphasizing the transferential issues in family play therapy maintains the focus of family members on each other. To change an individual requires one way of thinking, and to change the interaction among the family requires another. Family play therapy assumes a systems explanation for family therapy, and those therapists more accustomed to working with the medical model may feel uncomfortable relinquishing their status in the session.

Counter-transferential issues may also present problems. Working with the two generations, a therapist may become more invested in the "child-victim" or in the parent. With two parents present in the room, the

therapist may feel more natural empathy with one or the other. Indeed, with several people in the room, counter-transferential feelings are multiplied, and the therapist needs to be highly attuned to his or her own feelings surrounding the issue at hand in order to prevent being triangled by the family.

At times, a therapist may be unable to let the family secret emerge because of personal discomfort with the issue. As the treatment progresses, the child will eventually expose the family secret in front of the parent. The therapist's anxiety as this occurs, may covertly encourage the repression of the secret and escalate the family's anxiety. Extensive work with one's own family of origin is recommended to insure clarity about counter-transferential issues (Carter & Orfanidis, 1978).

The entire issue of when to allow the family secret to surface is a judgement call based on the therapist's accumulated knowledge of working with families. The danger is that the family will terminate when the secret is exposed, and the therapist needs considerable skill to shift the focus to marital issues from the child-focused problem. Of course, in traditional play therapy, parents will often discontinue treatment after the child becomes asymptomatic, so this difficulty is not peculiar to family play therapy.

Finally, this approach should not be used in all child-focused cases. Family play therapy would be contraindicated, for example, when the therapist suspects child abuse. The abusive parent should be seen alone since there is a risk that revealing secrets in his or her presence could result in physical danger to the child at home. However, the non-abusive parent could be seen in play with the child in such cases where there is little danger of this parent triangulating around the child at home and revealing toxic material to the abusive parent.

There are also cases where a particular child has serious psychological deficits (e.g. schizophrenia) that are not totally related to the family situation. In the early stages of treatment with such a child, parents might find the nature of the child's communication confusing and bizarre, and find it difficult to participate with the non-judgemental attitude so necessary for the success of this method. The therapist needs to develop a special kind of trust and understanding with such a child; however once the child is better organized, there might be a purpose for family play therapy.

Conclusion

Most families respond with enthusiasm to family play therapy, however, the key to its success lies with the therapist. Not every therapist can util-

ize this technique to its full advantage. The therapist must be able to do what she is asking the parent to do, and that is let the child inside the adult out to play. In fact, there may be few therapists with the necessary flexibility to enter into the spontaneous world of childhood (Schaefer, 1981). Florence Lieberman (1979) writes: "Those who work with children must be flexible, tolerant of noise and messes, and they must value and respect children" (1979, p. 294). The family play therapist must be in touch with the child in herself, which allows her to respect the young client, however, she must also be able to include the parents in that respect, and have a gift for releasing the child in the parent.

As Fogarty (1979) often suggested, "Adults are large children, and children are small adults, but aside from that there is little difference." Family play therapy maximizes the ability of the child and the "inner child" of the parent to communicate on an equal level and offers a powerful modality for working with adults, who themselves were children at one time. In the atmosphere of mutual trust, long repressed feelings and family secrets can be revealed, and each family member can be empowered to make positive change.

References

Anderson, C. M. (1983) A psychoeducational program for families of patients with schizophrenia, In W. R. McFarlane (Ed.), *Family Therapy and Disturbed Families*. New York: Guilford Press, pp. 99-117.

Anthony, E. J. (1980) The family and the psychoanlytic process in children, *The Psychoanalytic Study of the Child, Vol. 35*. New Haven: Yale University Press.

Bowen, M. (ed.) (1978) *Family Therapy in Clinical Practice*. New York: Jason Aronson.

Braverman, S., Hoffman, L., and Szkrumelak, N. (1984) Concommitant use of strategic and individual therapy in treating a family, *The American Journal of Family Therapy*, Vol. 12, No. 4.

Brinich, P.M. (1984) Aggression in early childhood: joint treatment of children and parents, *The Psychoanalytic Study of the Child, Vol. 39*. New Haven: Yale University Press.

Carter, E., and McGoldrick, M. (eds.) (1980) *The Family Life Cycle*. New York: Gardner Press, Inc.

Carter, E., and Orfanidis, M.M. (1978) Family therapy with the therapist's family of origin, In M. Bowen (ed.), *Family Therapy in Clinical Practice*. New York: Jason Aronson.

Ekstein, R. (1976) Psychotherapy in american and in europe: the twain shall meet. Foreward by H. Argelander, *The Initial Interview in Psychotherapy*. New York: Human Sciences Press.

Ferreira, A.J. (1963) Family myths and homeostasis, *Archives of General Psychiatry*, 9, pp. 457-463.

Fogarty, T. (1979) On emptiness and loneliness, *The Family*, Vol. 6, No. 1.

______. (1978-1979) Lecture notes. New Rochelle: Center for Family Learning.

Freud, S. (1913) *Totem and Taboo*. S.E. 13.

Gardner, R. (1981) Mutual storytelling technique, In C. Schaefer (ed.), *The Therapeutic Use of Child's Play*. New York: Jason Aronson.

Ginsberg, B. (1976) Parents as therapeutic agents: the usefulness of filial therapy in a com-

munity mental health center, *American Journal of Community Psychology,* Vol. 4, No. 1, pp. 47-54.

Guerin, P. and Gordon, E. (1983) Triangles, trees and temperament, New Rochelle, N. Y.: Center for Family Learning.

Guerney, B. (1964) Filial therapy: prescription and rationale, *Journal of Consulting Psychology,* Vol. 28, No. 4, pp. 304-310.

———, Guerney, L.F., and Andronico, M.P. (1981) Filial therapy, In C. Schaefer (ed.), *The Therapeutic Use of Child's Play.* New York: Jason Aronson.

Haley, J. (1963) *Strategies of Psychotherapy.* New York: Grune and Stratton.

Hambridge, G. (1981) Structured play therapy, In C. Schaefer (ed.), *The Therapeutic Use of Child's Play.* New York: Jason Aronson.

Haworth, M.R. (ed.) (1964) *Child Psychotherapy: Practice and Theory.* New York: Basic Books.

Herz, F. (in print) Single parent families, In E. Carter and M. McGoldrick (eds), *The Family Life Cycle.* Second Edition. New York: Gardner Press.

Hobbs, N. (1962) Sources of gain in psychotherapy, *American Psychologist, 17,* pp. 741-747.

Jackson, D.D. (ed.) (1968a) *Communication, Family and Marriage, Vol. 1.* Palo Alto: Science and Behavior.

Karpel, M.A. (1980) Family secrets, *Family Process,* Vol. 19, 3, pp. 295-306.

Klein, M. (1981) The psychoanalytic play technique, In C. Schaefer (ed.), *The Therapeutic Use of Child's Play.* New York: Jason Aronson.

Lieberman, F. (1979) *Social Work with Children.* New York: Human Sciences Press.

———. (1986) Personal communication.

Moustakas, C.E. (1964) The therapeutic process, In M.R. Haworth (ed.), *Child Psychotherapy: Practice and Theory.* New York: Basic Books.

Pincus, L., and Dare, C. (1978) *Secrets in the Family.* New York: Pantheon Books.

Schaefer, C. (ed.) (1981) *The Therapeutic Use of Child's Play.* New York: Jason Aronson.

Stanton, M. D. and Todd, T. C. (eds.) (1982) *The Family Therapy of Drug Abuse and Addiction.* New York: Guilford Press.

Straughan, J.H. (1981) Treatment with child and mother in playroom. In C. Schaefer (ed.), *The Therapeutic Use of Child's Play.* New York: Jason Aronson.

Thomas, A., Chess, S., and Birch, H.G. (1968) *Temperament and Behavior Disorders in Children.* New York: New York University Press.

Umana, R.F., Gross, S.J., and McConnville, M.T. (1980) *Crisis in the Family.* New York: Gardner Press, Inc.

Vaillant, G. E. (1977) *Adaptation to Life.* Boston: Little, Brown and Company.

West, J. (1983) Play therapy with rosy, *British Journal of Social Work, 13,* pp. 645-661.

Winnicott, D.W. (1980a) *Playing and Reality.* New York: Penguin Books, Inc.

Woods, M. (1982) Childhood phobia and family therapy: a case illustration, In F. Lieberman (ed.), *Clinical Social Workers as Psychotherapists.* New York: Gardner Press, Inc.