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PRACTICE NOTES
Specific Cases, Techniques and Approaches

Are the Children Playing Quietly? Integrating Child Psychotherapy and Family Therapy*

Elisabeth Scott**

Over many years, family therapy training programs have not included the engagement of children under seven. John Byng-Hall wrote in 1986 that family therapists could learn about understanding young children from child psychotherapists. It has long been my practice to include young children when working with families. This article describe ways of working that include young children's play as relevant information. I hope to encourage other child psychotherapists and family therapists to find better ways of integrating skills.

HISTORICAL AND THEORETICAL CONTEXT

Early in my career I was inspired by reading Virginia Axline's *Play Therapy* (1947) where she describes play as the child's natural medium of self-expression, through which feelings of tension, frustration, insecurity, aggression, fear, bewilderment and confusion may be discerned. Axline's *Dibs* (1950) is a text with which many are familiar. The treatment of Dibs is described with warmth and tenderness and the resolution of his troubles has been an inspiration to many child and family therapists. At the time of my reading of Axline's two texts I was a teacher of speech and drama, working to encourage talking in children with a long history of institutionalisation. Drama improvisation was a way of beginning the process. The children began to talk and to tell their stories but I was not equipped to do anything other than hear them. In the early 1970s, formal training programs in child psychotherapy were not available in Melbourne. My determination to be more useful to children led me to undertake some five years of training seminars to become a child psychotherapist. Infant observation is an integral part of child psychotherapy training and I was privileged to observe an infant and her mother from ten days old to eighteen months. This study meant visiting the home of the family for one hour each week to observe in detail the relationship as it developed between the mother and infant. The observations were recorded sequentially and later discussed within the theoretical frameworks of (for example) Melanie Klein, Donald Winnicott, Bruno Bettleheim, Wilfred Bion and Anna Freud. It seemed to be a long way from speech and drama and was exciting as well as arduous.

As a child psychotherapist at the Child Psychiatric Clinic in Singapore for nearly three years, I had the opportunity to test out my learning and techniques within a cultural setting in which I was the 'alien'. Singaporean children asked *permission* to play and often chose to draw beautifully rather than explore the play materials. It was while in Singapore that my interest in family therapy was aroused, when I found myself in a position of interviewing families but had very little theoretical knowledge of how to approach the task. There were visitors passing through the country who brought with them their experiences of working within the framework of family systems therapy. It was at that time that I first read Sue Walrond-Skinner's *Family Therapy: The Treatment of Natural Systems* (1976). As a basic text for a beginning family therapist Walrond-Skinner's book provided some sound ideas.

Back in Melbourne I was invited to join the Child Psychotherapy Discipline in the Department of Psychiatry at the Royal Children's Hospital. I worked in the psychiatric inpatient unit for eighteen months until its closure, and then worked as part of an outpatient/inpatient team. During this period of just over four years I studied psychoanalytic theory, reading Freud and Lacan. However, it seemed clear to me that one-to-one work with children was not enough. The child could make dramatic changes in therapy but did not have the authority necessary to effect changes in the family and thus was placed in the position of having to forfeit change so as not to upset the balance in the family functioning.

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**Formerly child psychotherapist and family therapist in private practice, Aspendale, Victoria. Elisabeth Scott is now retired. Address for correspondence: Villa Dom Perignon, 33 Bd. Settimelli Lazare, 06230 Villefranche-sur-Mer, France.

The progression to family therapy training appeared an obvious one and I found myself the first child psychotherapist accepted into a family therapy training programme in Melbourne. A new set of authors and a new language entered my world. Minuchin, Satir, Haley, Hoffman, Watzlawick, Nagy, Bateson, the Milan Group and later White influenced my way of being with families. All this learning was exciting but I found myself troubled. Sue Walrond-Skinner suggested that few people included children under the age of eight in family therapy and went on to describe this as an illogical boundary to the system. John Byng-Hall (1986) wrote that the therapist can provide a relationship equivalent to the secure attachment in which new relationships can be explored by the child; as soon as the therapist has been tested and found strong enough, then family scripts can be re-edited. Luepnitz (1988) described a feminist object-relations family therapy in which the therapist creates a holding, caring environment so that the family can explore relationship issues and symptoms within the transference and countertransference.

I had worked so hard to acquire skills and knowledge in working with children that it seemed a waste to not find a way of integrating them with the new skills and knowledges from family therapy. It somehow didn't seem good enough for me to put a box of toys in the corner and hope the young children would be quiet enough for me to get on with the 'real work' of talking with parents, or of conducting parent education in the presence of children. I wasn't happy with using stock phrases such as 'Have you noticed how the noise level goes up when we mention touchy subjects?' or accepting the apparent belief that children are oblivious to the dynamics in their families. So it was incumbent upon me to find ways of working that seemed most satisfactory to me and reasonable for my clients.

REASONS FOR EXCLUDING YOUNG CHILDREN FROM THERAPY

In many early family therapy texts the major focus was on engaging children who are school age and over, and there seemed to be many reasons for excluding young children from the process. This descriptive list is by no means definitive; I am sure that many readers can add to the list without difficulty.

1. It is all too hard and time-consuming

a) It may be too much trouble to ensure that young children are present in a session.

b) It takes time to take a thorough history in order to make an assessment of the needs and best interests of the child and family. (Young children recovering from severe trauma, obsessive-compulsive disorder or from the loss of a parent may do better in one-to-one child psychotherapy. It may be useful to arrange three individual assessment sessions with a young child alone, after the initial family meeting and then give feedback to parents. The next step then is to work with the parent(s) and child(ren) all together.)

c) When negotiating with referring agents and parents about the inclusion of young children in family work, the therapist may experience pressure, either overt or covert to 'fix up the child and the whole family will be all right'.

2. Young children can be a distraction for the therapist

They fall over, want drinks, climb on chairs and tables (Carpenter and Treacher, 1982) and their parents are so anxious that they seem paralysed and either unable or unwilling to impose any sort of order. The therapist is equally paralysed, having been given a message as trainee that to take charge of children during the course of therapy can undermine the authority of parents. At best, this can mean a loss of concentration for parents and therapist. At worst, it may increase parents' feelings of incompetence.

3. Inhibitions felt by therapists

The therapist may have some reluctance to get too close to the child within, or may be inhibited by feelings of protectiveness towards children. Since the therapeutic world has been sensitised to child abuse the inhibitions felt by therapists can be quite overwhelming.

4. Shifts and translations

Making shifts and translations from the world of the young child to that of the adult is tricky for a therapist who is not familiar with children. Pacing is difficult because children process at a different rate from adults; so having young children present means constantly checking that the pace is right for all.

5. Lack of knowledge

Lack of knowledge of aspects of child development (Ilg and Ames, 1955; Sanders, 1985) can shift the focus of therapy. The presence of an infant under one year can invite the therapist to focus on the mother's ability to meet the needs of the infant, the father (he feels excluded), or other siblings. As the infant grows to be a toddler the focus of therapy may be on the demands of that toddler, sibling rivalry or parenting control issues, irrespective of whether or not these form any part of the presenting problem. Three to five year olds are engaging and it is likely that these youngsters will enchant and distract the therapist, sometimes to the irritation of the parents. Most professional workers will claim that they know all about child development because it was taught during their early training. However, my experience is that few remember that small children react to the emotional state of the adult carer(s) and that until the age of three memory is limited. It is easy to forget about the impact of early separation issues, and the implications that incomplete or unresolved separation issues can have for the future in the life cycle of the family (Klein, 1975; Winnicott, 1978).

6. The therapist's workplace

The therapist's workplace may not be conducive to including young children in therapy. The presence of noisy small children may be an unwelcome intrusion into the work of other professionals.

7. Talking about children in their presence

Talking about children in their presence can be difficult for therapists and parents. It is easy to forget that children are a part of the family process all the time and are neither deaf nor blind (Sanders, 1985). Both parents and therapists tend towards the view that it may not be good for children to hear negative views expressed about them, despite the child being 'the identified problem'. My view is that children do know why they are brought to therapy and that it can be helpful for them to hear what is said so that they may have an opportunity to respond in their own way.

8. Managing private issues

There may be difficulties in knowing how to manage private (particularly sexual) issues for couples when young children are present. This is probably the only legitimate reason to exclude all children from therapy.

CREATING SAFETY

A workplace conducive to the noise and activity level of young children is not of itself enough for the creation of a safe space for them. There are other aspects that help them to feel welcome and secure and encourage them to share information with the therapist.

Some time ago I was working for a few hours a week in a local agency and met a two and a half year old. His seven year old brother was 'the problem'. The agency welcomed children of all ages, so I knew that managing the children's behaviour my way would be OK. The mother, a sole parent, told the story with many interruptions from David, the younger boy, while the older one sat peacefully. David climbed everywhere, pushed his brother off his chair, hit, kicked, spat, opened all the drawers and generally created mayhem. Mary's story was larded with 'Don't do that', 'Stop climbing', 'Play with toys', etc. She looked tired and dispirited and I felt sorry for her. Eventually, David climbed on to my desk—he played right into my hands! I excused myself from Mary, went to the desk and silently lifted the phone, my papers and light off the desk and out of reach and resumed my seat. I knew two important things. First that David would quickly become frustrated because he was ignored. Secondly, that it is safe for small children to cry for up to fifteen to twenty minutes before they lose contact with reality (Klein, 1975). I sat, holding Mary's hand and talked softly with her about being so tired because she worked so hard looking after her children, that it was very difficult to resist David's invitation to her to pay attention to him. As his crying became more insistent, I talked of how painful it was for her to hear her son crying and not do anything about it and explained that I would be sure not to do anything unsafe. In the meantime, Mark (the so called behaviour problem child) sat quietly reading, glancing only occasionally at his mother and brother. After fifteen minutes or so I told Mary that I was going to assist David. I got up, placed a chair in front of the desk and encouraged David to climb down, saying 'There you go, David' as I patted the chair. In silence, David climbed down and began to play beside his brother and then beside me.

At the end of the session, David took my hand as we walked to the door together and then kissed me good-bye. When the family returned, David used my name, didn't bring with him the three dummies he had brought the first time, played appropriately beside his brother and made no attempts to disrupt his mother's conversation. Subsequently, Mary worked through her own issues, accepting that she was a good mother to her sons. The intervention that I have described would not have been possible had the agency context been an adult one where children's noise was not welcome.

Child psychotherapists agree that to the young child, play is its work (Winnicott, 1978; Moustakas, 1974; Axline, 1964). In play young children express fears and fantasies and try to resolve their feelings. They have insufficient language to give words to feelings and play is their best medium of explanation. Age-appropriate material should be available for small children in the therapy room. Good knowledge of child development will inform the choice of suitable age-appropriate play materials. When selecting, it is wise not to include noisy playthings such as drums. Small children like to bang things together and drums are often too much for some adults. Broken toys are not a good idea, because small children may have the fantasy that they have caused the breakage and the space becomes less safe for them. There are always those children who like to see how toys are made and appear to want to break them. Small children do want to investigate how things work, but the investigation can cause major distraction to therapist and parents. I find that the best way of managing this is to let the little person know that I have noticed the activity and that if the plaything breaks it might not feel safe for her/him, and if that seems so to me, I will make it safe by looking after it. If the investigation continues, I reach out for it and say I will keep it safe. I find that this technique saves a lot of time and avoids a battle.

A doll house and a selection of small people dolls are essential equipment in my practice.

Andrew was four when we met. His parents had separated because his baby brother had a different father from Andrew and his two older sisters. While his parents were telling me the story, Andrew moved over to play with the doll house in the corner of the room. He settled the family dolls in two rooms and quietly moved them from one position to another. As I observed his play from the corner of my eye, I noticed that one of the dolls was often tossed out of the house and even thrown over the roof. This fascinated me so I asked the family would they mind if I spent a bit of time with Andrew. They gave permission and so did Andrew, so I joined him on the floor in the corner and asked about his play. He told me that the family had two places to live and that they visited each other. I gently asked about the visiting person who kept being thrown about and wondered aloud what this meant. Andrew's family sat spellbound as he explained that this doll was the boy who had been angry with his father and his father had to be sent away from the family, so the boy had to be thrown out because he was bad. Andrew went on to tell me that he

had been visiting his father, who had left him with his paternal grandparents while he went to the football and Andrew had felt very angry with him.

Several new things happened as a result of Andrew's story. His parents joined together to tell him the real story of their separation and to reassure him that he was loved equally by them both. Andrew's wish was understood and his father promised to pay him more attention in the future. The parents' joining to support Andrew led them to negotiate a harmonious way of sharing the parenting of their children in spite of their separation. Perhaps the most impressive consequence of Andrew's story was his thirteen-year-old sister's request to talk to him about anger. Her father had complained bitterly about her angry outbursts to him. She told Andrew simply that it is OK to be angry with parents because you know that they love you enough to be able to withstand your anger and help you to move on from it. Her father was amazed to hear this and recognised her as loving him, so that he could go on loving her.

In this case, the play equipment provided the vehicle for Andrew to express his fantasy. My attention to his play enabled the family to hear it and to recognise his need to know the facts of the separation. His sister was able to educate Andrew about anger, and new relationship negotiations began between parents, and parents and children. These changes all occurred in one interview! There was still a lot of work left to be done, but this session provided a platform from which to work together.

I think it is useful to observe the sequence of children's play and to avoid invading their space too quickly. Children have a right to their space so I usually acknowledge them, remember their names and never touch them unless they touch me first. Toddlers will observe adults for a long time before making any moves towards them and their advances usually take the form of dropping toys into open hands or onto a handy lap. I don't think it is necessary to go down on haunches in order to put my large, strange face close to that of a toddler. I just accept their advances without judgement. Small children often play out their feelings, because they have not yet learnt how to talk about them. Sometimes it helps when the therapist gives names to the feelings, sometimes it can be more productive to ask parents to provide the words. The therapist can give a lead to parents by being prepared to get down on the floor and participate in the play as a way of encouraging the family to include their young children more in therapy.

It is always interesting to observe the parents' amazement when their children do know the answers to questions asked by the therapist. When young children are asked a question and there is a pause, parents are tempted to say quickly 'Answer the lady, you won't get into trouble'. I think that is guaranteed to maintain the child's silence. It helps to ask parents not to put pressure on the child. The therapist must be patient; the answer may come after a few minutes and may not be in words. Paying attention to the play as well as the words is the only way to begin to make sense of children's communications. Writing notes during the course of a family session helps with pacing the meeting, gives the therapist time to think, provides an accurate record of the interview and permits the sequential recording of children's play so that it can be understood in relation to the family interactions.

Young children like to know the rules wherever they are. In my private practice I am happy to explain to families that the rules here may be different from rules in other places they have visited. I tell them I consider it my responsibility to make the room and them safe; the toys have no sharp edges and children should feel free to explore for themselves. (I remove any small objects which might be swallowed by newly mobile infants.) Should a child climb a chair and I begin to feel anxious, I let parents know that I will lift the child down. I usually ask parents if they are comfortable with the arrangement, and when we are agreed, then we proceed.

A five minute warning of the end of a session is always given to young children and I let them know that clearing up is part of my expectation. Five minutes to the dot is when the session ends and the child is then encouraged to pack up. Often I will join in the packing up to avoid the battle that can occur just after a 'brilliant' intervention has been delivered. We all know the moment when the next appointment has been made, the intervention delivered, the door opened—and then parents insist that the young children must pack up the toys! The intervention loses its impact because of the racket that ensues. When the rules are explained clearly, the process of packing up provides a happy space and the young child will feel safe to return. Children don't like to leave adults in a mess; they can be fearful of returning to face the consequences of their mess the next time. The packing up done, everybody goes on their way feeling that the ending was appropriate.

There are times for some families where their high level of distress comes with them into the therapy session. It may be that a young child or parent is physically unwell, or that the family is experiencing a particularly chaotic phase. The therapist makes a valiant attempt to obtain useful information but the noise of the distress takes over. On these occasions the wisest thing for the family and therapist may be to abandon the interview, make a new time and agree to start again. When the therapist is compassionate, rather than judgemental, the family is most likely to experience relief and will return to participate in the process of change with renewed confidence. My experience is that this way of dealing with distress is preferable to allowing behaviour to deteriorate to the point where parents make threats of smacking or sending children outside to wait for them or even saying that the therapist will not let them come to this place again.

PROVIDING SPACE TO TALK

The therapist who creates a safe environment for young children and their parents is already well on the way to providing a space to talk. The therapist who is prepared for the lurid fears and fantasies of small children will not be taken by surprise. When a toddler presents a picture it

works better to say 'Tell me about your picture' than to proclaim it 'good' or 'beautiful'. It may not be 'good' or 'beautiful' to the toddler. By giving him/her an opportunity to tell the story of the picture, the therapist will learn about the toddler's view of her/his world, sense of time and position in the family (Zilbach, 1986). To a three year old, three years is a lifetime's experience and for the therapist who is genuinely interested in that experience and its meaning for the little person, the possibility of discovering new information is unlimited.

Some years ago, when I was working in an agency, a young family was referred because the couple seemed likely to separate. The woman had epilepsy and her husband said that because of the effects of her medication she could not have thought of the idea of leaving him by herself. He said that most probably her mother had put her up to it. At our first meeting the three year old's activities were all over the place but she did make a beginning contact with me via 'the tea ceremony'. Towards the close of the session it was my task to negotiate the fee to be paid by the couple. At that moment the three year old wanted to go to the toilet; her timing was impeccable. Her mother took her to the toilet, having given permission to her husband to continue to negotiate the fee. He didn't know the precise sum of his weekly earnings because he handed the information to his wife for her to do the banking. Nor did he know how much the family paid in rent or the amount paid each month for the family car. It seemed that his wife, too dumb to be capable of deciding to leave him without input from her mother, was in charge of all the family's finances. To prove that she was in charge of the money and that he wasn't really committed to the idea of the need for change in the family, she paid the fee each time they came. One day the three year old came in wearing a handbag; her father had begun putting her to bed and reading stories instead of coming home from work and sleeping on the sofa in front of television. At the end of this meeting the little person opened up her handbag, took out her play money and brought it over to me saying 'There's my money'. That day the fee was paid by the father for the first time. I was impressed by the little girl's knowing what information to bring and when to bring it for her parents.

There are times when children will happily answer questions posed by the therapist and then will suddenly change the subject. This is not a rude refusal; it is more likely to indicate that the question is too difficult, the answer too compromising, or simply that for the time being the child has lost interest. The therapist needs to check that the words used in the question are clear and then to accept that to continue will break a connection which is finely balanced. Both children and parents can accept the therapist's explanation that 'It seems as though you [child] have had enough questions just now'. Perhaps the least productive questions for adults in therapy are 'why' questions, which receive the same unproductive answers—or silence—when directed to young children, and can safely be put aside.

I have found that children respond to positive more readily than to negative language and so I tend to talk of making things safe rather than saying 'No' or 'Don't do that!' When the therapist is careful about the language used, children will find it easier to respond.

USING YOUNG CHILDREN'S INFORMATION

There are many ways of using the information that young children bring to enrich and inform the therapist and the family.

Some years ago a four year old was referred to me at the Royal Children's Hospital because of poor sleeping patterns. He had been examined by the paediatrician and no physical cause could be found. During the first interview I was approached non-verbally by him: he placed his chair so close to me that I could feel it against the side of my leg. I felt prompted to put my left arm around his shoulders, and wrote the incident in my notes. The parents kept a log of his sleeping, or more accurately his non-sleeping and brought it next time they came. I gathered information from the parents and the little boy played quietly, always near my chair or behind me. When the third interview took place, I was feeling at a bit of a loss as to how to proceed. The little boy went straight into the corner of the room to play as usual so it seemed to me that nothing was any different. And yet I was still struggling to understand what had prompted me to put my arm around him in our first session. It was an uncharacteristic gesture from me, so soon after meeting him.

As the interview got under way, his mother told me that she found her son quite uncontrollable at home. She opened her handbag saying 'I have to use this to control him', produced a two inch leather belt with a metal buckle on the end. Then I knew why I had put my arm around him; he was an abused child. For a split second I froze before inviting the mother to give the belt to me to look after for her until our work together was finished. By providing a safe space for the little boy I had also provided a safe space for the mother to disclose the abuse (Luepnitz, 1988). I have often wondered what might have been missed had the little boy not been present or his information not heard. The inclusion of small children in family work can serve to remind therapists to be alert to child abuse and to effect change as early as possible.

Young children create links and give indications of connectedness in families.

Recently, an eleven month old helped his parents to make a decision together. I had seen the young woman for some time and she had come to regard me as her therapist. Her husband was asking to be included in the therapy and to do some individual work and she was resisting this idea vigorously. I was reluctant to be involved as the decision maker and was rescued by the baby. Just when negotiations reached an impasse the infant stood up and made his first independent steps from his mother to his father. We all stopped to exclaim on how clever he was and he stood smiling and slapping his stomach. He turned to me with a grin and then walked three more steps from his father to me. While we continued to praise his prowess and congratulate ourselves on being witness to this marvel of developmental progress, he calmly walked from me back to his mother. The triangle of connectedness was complete. His mother said 'That's it then, we all come here together'. The baby's timely intervention had changed the pace and the tone of the meeting, and enabled his mother to give up her notion of 'ownership' of the therapy and the therapist.

Sometimes it is appropriate to spend time with children alone to give them an opportunity to speak for themselves through play. One or two individual sessions can help a young child to find her/his own voice, find

words for feelings, and advocate on her/his own behalf to the family. The work need not pathologise the child, but can be put into a developmental or interactional framework. Together the family can then find new solutions.

When a two and a half year old was brought to me by her grandparents they told me that they were puzzled because she was refusing to stay in her cot at night. They were concerned that she had been frightened by something or someone and they were unable to persuade her to settle to sleep as well as she had done in the past. I spent three separate 40 minute sessions with this delightful little girl. At first she tipped out all the toys and checked out the rules about climbing and touching everything. After a while she decided to draw. She became intimate as she made her pictures on the paper and discarded well-articulated words in favour of whispered jabber, interspersed with words such as 'nanny', 'daddy', 'mummy' and the names of other people in her life. We built castles together and then she began to play at going to bed and getting up. She was very much in charge of her own play and referred to me only occasionally. Her game seemed to be showing me that what she wanted was to find her own way of managing her bedtime fears. She talked of the dark and dreams. At no time did she demonstrate any fear of the people she mentioned, nor did she show any fear of me, nor of going to bed. When I discussed the bedtime routine with her grandparents they decided that perhaps it was time to make changes. They thought that they would give time to stories and quiet cuddles before putting her to bed, maybe they would leave a night-light on and they would stop telling her she had to stay in bed. The toddler's activities showed that she was acting in the way two and a half year olds do as they assert themselves and begin to want more control of their environment. The separate time with her gave the opportunity to reassure the grandparents and the toddler, and hopefully avoided some battles for control.

Some of the most rewarding work can be achieved with young mothers and their infants. I often see sole parents as well as partnered mothers, referred by local Maternal and Child Health sisters. Being a new mother is anxiety provoking, and learning the language of the infant can be a daunting task. The birth experience can reawaken old unresolved issues and interrupt the bonding (attachment) process. When the therapist connects the mother's feelings to the infant's reactions she normalises the process and the mother learns a new language of connectedness.

A young sole parent brought her infant son with her. She complained that she was fearful at night and that her seven month old kept her awake. She often became angry with him and was afraid that she might damage him. She had been sexually abused when she was small. We talked together about his being a big baby and about how noisy he could be. The mother found it difficult to hold him, particularly at feeding time and she recognised that this was the most anxiety provoking time for her. She sat holding her son close to her and began talking about her experiences as a child and her determination to overcome the memory of her own abuse. The infant became increasingly restless and she quickly decided that holding him at that time was not useful. She gave herself permission to put him down and to touch him from time to time and was amazed at how well he settled. She then decided that her feelings communicated themselves to the baby and that when she was at home she would try the same technique. Because feeding time and bedtime were her most difficult times, she worked out new ways of dealing with them so that she separated her own fears from her wish to look after her baby in the best way possible. This young woman was eager to learn and found parent education classes to supplement her knowledge. She worked hard to come to terms with her own abuse separately and realised that she had moved away from the possibility of continuing the cycle of abuse.

CONCLUSION

There are many arguments for excluding young children from family therapy, or for including them only so long as they are quiet enough. I think that there is a place for including every family member in family work and it is the task of the therapist to find a way of engaging them all. In this article I have tried to show that through creating a safe space for young children to be heard through their play as well as their words, their contributions can be as respected as much as those of the older, more articulate members of the family. Perhaps the most valid reason for including small children is the preventive work that can be achieved. Each time we see two adults with their child, we are seeing not two but three parents and our work is then geared towards making something better for the next generation. And apart from anything else, working with small children is fun!

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