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PAIR PLAY THERAPY: A RELATIONAL INTERVENTION WITH YOUNG CHILDREN

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Theoretical Framework and Rationale for PPT

Pair Play Therapy (PPT) is a developmental intervention designed to help at-risk toddlers and preschoolers develop and sustain friendships with agemates. PPT is based on Selman and Shultz's model of pair therapy (1990) and influenced by the work of Lourdes A. Carandang (1992), Kurt Fischer (1984, 1994), Dante Cicchetti (1989), and Daniel Stern (1985). Our model for working with young children is more than just a program of clinical intervention; it is also a vehicle through which we study developmental processes. PPT builds upon children's existing abilities and interests to promote their growing interpersonal competence.

Interpersonal competence is here conceptualized as the capacity to coordinate social perspectives — i.e., to differentiate and integrate the thoughts, wishes, and feelings of self and other (Selman & Shultz, 1990). The emergence of this capacity in early childhood can be inferred from young children's growing ability to help others who are distressed in ways that are appropriate to their needs (Eisenberg, 1992), to anticipate others' reactions and participate in shared humor among family members (Dunn, 1988), and to co-construct pretend play performances with peers (Howes, 1992).

These studies suggest that under typical circumstances, children between the ages of 2 and 6 years gradually develop an increasingly sophisticated ability to recognize others' states of mind and to establish shared meanings. Although young children who are not yet concrete operational have an egocentric understanding of friendship (Piaget, 1967), the foundation for future perspective taking is being developed in critical ways by their relational experiences. As young children become more aware that thoughts and feelings, both their own and others, can be observed and recognized, they develop the capacity for self-reflective awareness (Stern, 1985; Kane, Raya, & Ayoub, in press). This capacity holds some parallel likeness to the same capacity for social-perspective coordination that develops among pre- and early adolescents (Selman & Schultz, 1990). However, in adolescence, this capacity arises from reflective thought processes while in early childhood it seems to be the manifestation of a pre-reflective intelligence in

action. Thus, the child's practical knowledge of how to negotiate her or his interpersonal world based on positive and negative experiences deeply informs the earliest foundations for their self-reflective understanding of both self and other. We believe that peer relationships provide an arena within which skills can be developed that extend to more general interpersonal competence and meaning-making.

The development of successful peer relationships can serve two important functions for at-risk children: to engender future positive interactions with agemates; and to provide opportunities to restructure representations of earlier, more negative social interactions that such children have often repeatedly encountered. Thus the promotion of positive peer interactions can serve as both intervention and prevention, alleviating social deficits and also laying a foundation for the successful negotiation of future developmental milestones. Constructive interactions have been found to have a long-term, positive effect (Rutter, 1990) which can serve to protect children from future developmental difficulties. An early ability to negotiate and establish successful peer interactions has been associated with favorable developmental outcomes (Hartup, 1992) and positive perceptions of schooling (Ladd, 1990).

From the outset, PPT has been conducted at inner-city daycare centers serving multi-risk, multi-ethnic populations of toddlers and preschoolers. The children typically come from homes where caregivers have to cope with extensive economic hardship and limited social support. Children at the centers have often been repeatedly exposed to illegal drug use, interpersonal and community violence, poor nutrition, and, in many cases, abuse, neglect and inadequate or inconsistent supervision. Without intervention, such children often develop inappropriate and ineffectual peer interactions. Despite the involvement of supportive agencies, these children are at high risk for developing divergent physical, psychological, and social development without alternative models for social interaction and development (Aber, Allen, Carlson, & Cicchetti, 1989).

A basic assumption at the core of our work is that development moves through successively more complex levels or systems (skills), thereby producing more complex cognition, emotion, and psychopathology. We assume no simple progression up a uniform ladder of stages. Rather, we believe that development occurs via richly varied, diverse pathways, molded powerfully by emotions and many other dynamically interacting influences (Fischer, Knight, & Van Parys, 1993). Unlike traditional views of psychopathology, we believe that most mental illness does not involve either fixation at an early stage or regression to that stage. Instead, we propose that psychopathology develops with increasingly more complexity over time, in a manner similar to other developmental skills.

While the development of new, more sophisticated skills is usually adaptive in a person's particular world, outside of that world these same skills can produce more sophisticated forms of difficulty and maladapta-

tion (Fischer & Pipp, 1984). Recurring, extreme emotional experiences caused by early trauma can fundamentally alter social-emotional development. Among the most important changes are a predominant negativity in representing self and social relationships and an elaborate, sophisticated splitting and dissociation of self and others. Research indicates that the repeated traumas (being maltreated, witnessing violence, experiencing parental conflict) often produce a cluster of fundamental changes in personality that include feelings of inner badness, and a basic fragmentation of the self (Buchsbaum, Toth, Clyman, Cicchetti, & Emde, 1992; Cole & Putnam, 1992; Famularo, Kinscherff, Fenton, & Ayoub, 1994; Herman, 1992).

Our preliminary work to date indicates that in seriously at-risk children, a natural propensity to develop positive representations of self and other is replaced by a bias towards negative representations. These children's emotions are often dominated by negative feelings, experiences, and enactments, and they endlessly talk about predominantly negative representations of events and interactions that have deeply informed their understanding and their development. Without intervention, this basic world view influences future perspective taking. It critically shapes the young child's most basic understanding of what relationships entail as well as the child's ability to make and sustain peer relationships. Furthermore, our work with toddlers, preschoolers, and older children suggests that such trauma leads to prominent difficulties with emotional regulation and cognitively mediated understandings of self and others at an early age (Calverley, 1993; Raya, 1993).

In reacting to the recurrent trauma, young children experience an intense struggle for control and competence. Judith Herman (1992) points out that the traumas "destroy the belief that one can be oneself in relation to others" (p. 53). Previous research suggests that the trauma of maltreatment, for example, is specifically associated with a delay in the development of a sense of self and also a contortion of the ability to get along with and understand others (Aber, Allen, Carlson, & Cicchetti, 1989; Mueller & Silverman, 1989). Our hope is that with early intervention, we can ameliorate or diminish both the negativity bias and splitting that are indications of the development of an alternative, and often problematic, developmental pathway in at-risk children. We believe that interventions that foster the development of relational skills and which provide opportunities for children to understand themselves and others are one way to address the developmental risks of chronic maltreatment.

The Pair Play Therapy Intervention

The process of PPT involves meeting weekly with pairs of children. During these sessions, the children choose their play while the therapists facilitate opportunities for them to interact together or help individual children find ways to express their unique concerns. The central focus of PPT is relational; the aim is to facilitate the development of social interaction

and to lay a foundation for the development of friendships in young children with social skill and interactional difficulties.

Sessions are guided by two supportive adults who observe or participate in the play as needed. However, the adults essentially remain in the background, striving to support and enhance the evolving relationship with the children. This support includes both recognizing positive interactions and redirecting negative or hurtful disagreements or behaviors. Therapists build upon children's existing abilities and interests to promote their growing interpersonal competence and to help them work on their interpersonal issues.

The PPT intervention emphasizes the following five objectives:

1) *To provide for the children a safe and nurturing holding environment.* Children who experience their primary caregivers as consistently available and emotionally responsive are able to construct an internal working model of significant others as dependable and accepting, as well as a reciprocal model of themselves as secure and accepted (Bretherton, 1985). In contrast, when children experience their primary caregivers as psychologically unavailable for extended periods of time, they are likely to expect significant others to be unapproachable and to see themselves as unworthy of loving. Moreover, when children experience their parents as abusive, unpredictable, or overdependent, they are apt to form a representation of significant others as dangerous and of themselves as bad or responsible (Crittenden, 1992). In PPT we endeavor to foster both positive peer relationships and also emotionally responsive care that is predictable and consistent from the adults. A global goal is therefore to provide a structured environment in which toddlers or preschoolers can safely interact with any other person, adult or child, participating in the Pair Play interaction.

2) *To enhance the children's readiness for peer interaction.* This is often a significant step for toddlers who tend to be less attuned to their peers. Therapists take a fairly active role in meeting this objective, as they try to incorporate the children in each other's activities and offer solutions to disagreements or hurtful behavior. Through modeling or structuring successful interactions, therapists endeavor to provide the children with a baseline experience of positive peer relationships.

3) *To prompt the children's use of communication, both nonverbal and verbal.* This is especially a challenge for children who tend to

be impulsive and physical with their peers. Such children are urged to slow down and indicate or explain their intentions when trying to either engage one another in play or settle disputes. Thus, with assistance from the adults, they are encouraged to practice the rudimentary skills needed to relate successfully.

4) *To promote turn-taking, as a simple form of reciprocal interaction.* This constitutes progress for children who tend to deal with one another through unilateral control or submission. Turn-taking is a provisional way to participate in the same activity and to resolve conflicts without having to entirely alter one's own actions or desires.

5) *To foster intentional cooperation.* This involves encouraging children to play complementary roles in shared activities or to find mutually acceptable solutions to disputes. Among young children, such planning often arises through the repetition of interactive routines, an integral component of autonomous relationship-building.

The aim of these five objectives is to both foster the children's awareness of, and empathy for, peers, and also to help them develop a growing independence from adult involvement. The objectives form a developmental sequence in which each objective creates the possibility for subsequent objectives to be reached. Despite this sequential model, we believe that interpersonal interaction can be influenced by a variety of factors, and a fixed, linear, age-related progression is not anticipated. Regression is, at times, the only possible course. Nevertheless, as PPT proceeds, a general trend in the direction of increasingly more collaborative interactions can usually be observed, both within each session and over the course of the school year.

Pair Play Therapy Model Implementation

Pair Play Therapy addresses what goes on both within and between children. It recognizes that children construct internal representations of self and of the social situations in which they engage. It serves to enhance competent interactive behavior between the children in the pair.

While children's play interests and interpersonal styles are vital components of their relationships through PPT, a safe and predictable therapeutic structure serves as the environment within which those relationships bloom. We have elected to bring PPT directly to the children in the daycare sites as these sites already serve as safe havens for these children. One of the overarching goals of daycare programs is establishing predictability in the children's lives through routines and schedules that their teachers develop

and provide. We envision and implement PPT in the same spirit of continuity and consistency.

Although there are frequently space constraints at our sites, as much as possible, PPT sessions are held in the same place every week. The preferred environment is a small but uncluttered room with moderate amounts of diverse, age-appropriate play materials. In contrast to older children, who often prefer to "roam" during therapy, toddlers and preschoolers depend upon the constancy of their physical surroundings in order to feel comfortable and safe. Though we strive for continuity, when space is limited, the pair play routines can often serve to provide the necessary consistency from session to session.

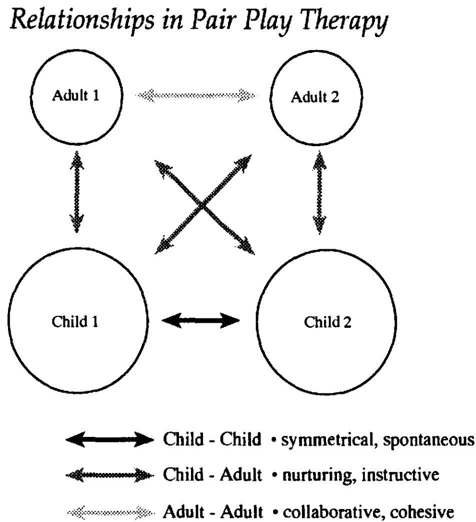
Clear expectations and predictable routines and rituals ensure children's well-being. Rules are simple: a) children cannot hurt themselves or others; b) children should care for play materials and room resources to the best of their ability; and c) children must remain in the PPT room. Even for the youngest participants, rules can be presented at the outset, though all children will need frequent reminders of the rules throughout the intervention period. Such rules are repeated during relevant interactions.

The PPT structure is also maintained through rituals that mark the beginning and the end of each session. Typically, before a session begins, children can be alerted that they will be coming to PPT at a certain point during their daily schedule. Upon entering the therapy room, they can be asked to plan their first activity, or, if during the course of their play they wish to change their activity, they can be encouraged to openly negotiate such changes with each other. Towards the end of the sessions, reminders as to the remaining time are often offered. The timing and frequency of such notices varies depending on the unique needs of each pair. Even the littlest participants are asked to help clean up before returning to class. Typically, we conclude sessions with this short clean-up phase followed by a good-bye song. These and similar rituals, which shift during a pair's development, assist children in anticipating and coping with transitions, thus freeing them to relax and invest in their play during the less structured parts of the sessions.

Generally, two therapists work together to establish a pair and conduct sessions. This serves to maximize support of the children through the continual availability of at least one adult. Our reliance on two therapists has been influenced by the work of Maria Lourdes Carandang. Her multi-interactional group therapy assigns one therapist to be with each child throughout a therapy session (1992). This ensures that the child never feels isolated or "lost" within the peer group. Both adults can respond to each child, as well as facilitate peer interactions. To achieve this end, the adult-adult relationship is collaborative and cohesive. Both adults are available and active for every session. They work together during the session, and consult with one another in meetings outside of the sessions.

The multiple relationships just described are illustrated in Figure 1.

Figure 1. *Relationships in Pair Play Therapy*



While the focus of PPT is on the peer relationship, the relationships developed with the PPT therapists — both adult-adult and adult-child — are important for establishing and maintaining a nurturing, comfortable environment. This is akin to a "holding environment," wherein children feel safe, accepted, and nurtured (Winnicott, 1965). Such a secure foundation serves as the base upon which children can venture into the less predictable realm of developing peer interactions, which we will illustrate in the following vignettes of a single pair of toddler girls.

An Example of Three Vignettes

In order to illustrate the process of PPT we offer three vignettes of two girls, Cristina and Tanisha, and their therapists. The girls had a total of 15 weekly PPT sessions together. They were referred to PPT as their classroom teachers noted that they were not interacting and playing together even though they were the only girls in the class. In addition, Cristina was observed bossing all her peers around. She often walked around the classroom with a frown on her face. Tanisha, on the other hand, appeared to be oblivious of other children around her and often played alone.

Session 1

Children begin engaging in their first play session in different ways. Cristina and Tanisha began by separately taking out furniture from the dollhouse and putting them on the table.

Therapist 1: (To Tanisha) That's a bed, yeah.

Therapist 2: (To Cristina) Somebody's sitting on the table?

Cristina:	No! (she sits two dolls on the table).
Therapist 2:	They will sit together.
Therapist 1:	We're running out of space. (Tanisha hands her a toy bed) What do you want me to do with the bed?
Tanisha:	(briefly laying her head down on the bed) A bed.
Therapist 1:	You want to lay down? Shall we take a little nap? Yeah? (She lays her head down on the bed briefly. Tanisha takes the bed from Therapist 1 and puts it down on the floor. She lays her head down on it.)
Therapist 1:	(To Tanisha) You close your eyes.
Therapist 1:	(To Therapist 2 and Cristina) Look! Tanisha's going to take a little nap.
Therapist 2:	Oh! Goodnight.
Therapist 1:	Sleep tight.
Therapist 2:	(To Cristina) Look at Tanisha, Cristina!
Therapist 1:	She's pretending she's asleep.
Therapist 2:	She's putting her head down on the bed. Good night, Tanisha.
Therapist 1:	Sleep tight. (Cristina puts a bed down on the floor)
Therapist 2:	Cristina, you also want to do that? Good night, guys.
Therapist 1:	Sleep tight. Night, night.

Often, as we will note with this pair, the children start off their PPT experience by interacting more with the therapists than with each other. This response is expectable as the children are trying to define the safety and meaning of the new environment for themselves. Part of this process involves taking cues from the adults around them.

At one point in this session, Tanisha brings a bed to show to one of the therapists and they talk about what to do with the bed. When Tanisha decides to "take a nap," the therapist uses this event as an opportunity to call the other child's attention towards her. The second therapist repeats the first therapist's observation. Having the children notice each other is one of the initial tasks we do in PPT to support the children's readiness to relate to each other. Cristina, in fact, notices, smiles and gets interested enough to pick up another furniture and moves to join Tanisha on the floor and pretends to sleep.

Session 8

We have noted across several pairs of children with whom we have worked, that their 6th to 8th PPT session marks a new level in the children's relationship. There is some form of "coming-together" that ranges from physical proximity to actual collaborative play, especially among the older preschool children that tends to begin around this time in the PPT process. In their eighth session, Cristina and Tanisha stand close together playing with kitchen toys:

Therapist 1:	We'll make hamburgers? (Pointing to the stove) It's hot.
	(Girls are turning knobs on the stove)
Tanisha:	(To therapists) It's hot.
Cristina:	(To therapists) This is hot.
Therapist 1:	That's hot too?
Cristina:	(Pointing to other pan) This is hot.
Therapist 2:	That's hot too.
Tanisha:	(To Cristina) Hot, Cristina. It's hot. (Looks at Cristina and bends her head to make eye contact.)
Cristina:	(To Therapist 2) Hot.
Therapist 2:	Tanisha's telling you it's hot, so be careful.
Tanisha:	(Looking at Cristina and gently tapping Cristina's shoulder) It's hot.

The vignette shows the two children comfortably sharing a close physical space. They have chosen to play with the same toy and engage in the same pretense activity, cooking. The two therapists continually reflect to them that they are both "cooking". Cristina takes a firm verbal claim on one of the toy cooking pots. Tanisha responds by "respecting" her claim. This minor conflict was not responded to by either therapist as the children were able to naturally resolve it without resorting to physical aggression. As we also try and support the development of symbolic play and thinking in the children in PPT, the therapists engage the children in "being careful around the stove when hot things are cooking."

The two children pick up on the conversation about being careful around a hot stove. Each of the children initially responds directly to the therapists who initiated the conversations on the "hot" topic. Then Tanisha turns towards Cristina to gently emphasize "Hot, Cristina, hot" while similarly gently tapping her on her shoulder. One of the therapists verbally supports Tanisha's direct attempts at relating and connecting.

Session 15

This is Cristina's last day at the daycare center and also her last day in PPT. She was scheduled to start attending a neighborhood daycare center in another part of the city the very next day. Her mixed feelings of anxiety, sadness, and some excitement were quite apparent in her behavior from the time she arrived at the daycare center. Tanisha was staying on at the center.

The vignette shows how Cristina initiates and engages Tanisha and the two therapists in play about people and things that turn into monsters. Her play, in which her play friend and the two adults spontaneously and fully participate, reflects themes of both fear and mastery of fears. In the first phase of this pretense, Cristina chose when fearsome things came out and when they were put away to "save" her friends. In the second phase she happily reverses roles with her peer, Tanisha, who then gives life to scary monsters and who also then takes care of or saves Cristina and the therapists by getting rid of the monsters. In this latter part of this pretend play, Cristina could freely allow herself to be fearful and to be physically held and shielded from the "fearsome monsters".

Cristina: (Growls as she holds out dolls towards Therapist 2: Aargh, aargh.

Therapist 2: Oh my! It's monster dolls!

Therapist 1: You're scared, Therapist 2? I'm scared.

Therapist 2: Oh! Tanisha, look!

(Tanisha moves towards therapists)

Cristina: (Reassuringly) I put them away. (Cristina puts dolls inside a shelf and then picks them up again and growls). Aargh, aargh.

(Tanisha runs to therapist 1 and hugs her)

Therapist 2: Oh no! Maybe Cristina will take care of us and put the monsters away again.

(Cristina puts dolls away. Tanisha and therapist clap their hands)

Tanisha: Yeah hey!

(Cristina repeats play, pulling out dolls again. Tanisha hides. Cristina puts them away and Tanisha claps joyfully again).

Therapist 2: (When Cristina brings out another monster) Oh no!

Tanisha: (To doll monsters in Cristina's hand) Stop! Stop!

Cristina: (Makes doll dance on table in a friendly way). Hi!

(Cristina has different family dolls turn to monsters. Tanisha acts scared, as do the therapists).

Tanisha: (To therapist 2) Don't be scared. (She hugs therapist 2, and strokes her hair). You okay?

Therapist 2: Yes, I'm okay. Thanks, Tanisha. Are you okay?

Tanisha: Yeah.

(Tanisha picks up some of the dolls and looks at Cristina and the therapists).

Tanisha: (Growling) Aargh! Aargh!

Cristina: (Smiling) Aargh! Aargh!

(Cristina drops her dolls and hunches her shoulders as she squeals, pretending to be scared by Tanisha's monsters. She runs to therapist 1).

Therapist 2: Tanisha, make the monsters friendly. Help us.

(Tanisha puts down the monsters while looking at Cristina. Cristina and the therapists clap their hands joyfully).

Cristina: (Handing dolls to Tanisha) Take them now, Tanisha.

Tanisha: (Taking dolls from Cristina) Aargh! Aargh! (Cristina hunches her shoulders again and hides her face in therapist 1's shoulders. Tanisha briefly puts away her dolls. The girls repeat this play two more times, each time ending the game by giggling and laughing together).

The therapists utilize the girls' usual kitchen play as an entry point for dealing with Cristina's departure from the familiar and imminent beginnings in a new environment. A "party" was to be held in her honor and so lots of "favorite foods were to be cooked." While in the process of these preparations the therapists talked about their sad feelings because they will miss Cristina and their excitement about the new things that Cristina will do and the new friends she will make in her new school. All through this talk the children were always made part of the conversation. Tanisha emoted freely showing both sadness and joy as she nodded her understanding of the meaning of Cristina's last day. Cristina, meanwhile, mostly kept quiet though engaged in the "cooking."

In their play illustrated in the vignette, the two girls show how far their relationship had evolved. Their implicit trust in their friendship is shown by roles they each played with and for each other, with minimal support from the therapists.

Conclusion

Pair Play Therapy is a relational intervention aimed at helping young children improve social skills and establish first friendships. As more and

more toddlers and preschool children enter group care settings, supports like PPT, for those children with emotional and social difficulties due to difficult life experiences become more and more crucial. The extension of the notion of a safe haven for emotional and cognitive learning can be promoted through the integration of such interventions into these settings. Early intervention at a time when children are learning basic interactive skills is an effective plan for reducing the effects of traumatic life experiences.

Currently we provide training in PPT for graduate students, early childhood teachers, and interested child and family therapists; through a year of supervised practice these professionals have developed and implemented PPT in both therapeutic and neighborhood early childhood centers and Head Start programs. Through this type of experience which includes guidance, mentorship, and consistent supervision, early childhood professionals can offer young children this series of healing experiences that over time have the potential to reduce the negative emotional and interpersonal difficulties that affect peer relations into later childhood.

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