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What is This?
Non-Directive Play Therapy for Young Children with Autism: A Case Study

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ABSTRACT
This article presents exploratory research on the feasibility of non-directive play therapy for children with autism. Video recordings of 16 sessions of play therapy with a 6-year-old boy with severe autism were analysed qualitatively and quantitatively. The study concluded that this child was able to enter into a therapeutic relationship and demonstrated attachment behaviour towards the therapist. Key areas of improvement were in the child’s development of autonomy and pretend play, while ritualistic behaviours showed only mild improvement. Changes in therapy were concurrent with the changes reported by the boy’s mother at home of increased independence and empathy. One implication of this preliminary research is that non-directive play therapy may enhance and accelerate emotional/social development of children with severe autism. More research is urgently needed; non-directive play therapy and behavioural treatments may complement one another to provide an overall treatment plan for children with severe autism.

KEYWORDS
attachment, autism, autonomy, joint attention, non-directive play therapy, symbolic play

NON-DIRECTIVE PLAY THERAPY is used for children and adolescents with a wide variety of emotional and behavioural problems (Guerney, 1984; Landreth, 1991; Ryan & Wilson, 2000; Wilson, Kendrick, & Ryan, 1992). However, research on using non-directive play therapy with children with autism is almost non-existent, based upon our own and others’ literature searches (Mitteldorf, Hendricks, & Landreth, 2001). Two case studies were found, one of a pre-adolescent girl with high-functioning autism, who had brief play therapy incorporating both directive and non-directive techniques (Kenny & Winick, 2000) and another of 18 months’ duration with a 5-year-old child who may have been higher functioning also (Mitteldorf et al., 2001). Behavioural treatments rather than play therapy are most frequently cited (Birnbauser & Leach, 1993; Durand, Gernert-Dott, & Mapstone, 1997; Lalli, Casey, & Kates, 1995; Lovaas, 1987; Strain, Kohler, &

Goldstein, 1996). More rarely, the value of psychodynamic/analytic play therapy has been discussed (Alvarez, 1996).

A few clinicians are beginning to advocate child-centred play therapy as a viable treatment for children with autism (Getz, 1996; Mitteldorf et al., 2001). In addition, there is an increasing emphasis in the child therapy literature on play as an ideal avenue for treatment of a wide variety of emotional and social difficulties. This emphasis on play fits in well with general trends in the autism research and treatment literatures. Researchers have attempted to identify pivotal individual markers in autism’s aetiology, such as imitation response (Dawson & Adams, 1984), ‘theory of mind’ (Baron-Cohen, Leslie, & Frith, 1985), and the domain of functional and symbolic play skills (Sigman & Ungerer, 1984), arguing that concentrating on these markers may benefit these children greatly. Identified markers may, in turn, unlock other developmental domains for children with autism and may lead to broader changes in a range of abnormal behaviours associated with this condition. For example, Mundy and Crowson (1997) suggest that joint attention and non-verbal communication skills should be a priority in pre-school intervention programmes, because these are pivotal in much socially motivated learning, such as symbolic play, language and social-cognitive processing.

Returning to play therapy, on a theoretical level, the therapeutic conditions provided by non-directive play therapy of unconditional positive regard, empathy and congruence (e.g. therapists’ use of their own feelings therapeutically as they arise within social interactions) and the method’s more recent emphasis on a developmental approach to treatment – all point to the possibility that this method may enable children with autism to benefit both emotionally and socially. The therapeutic condition of unconditional positive regard concentrates on accepting children’s current functioning, along with assuming that they possess an innate drive towards better functioning. In theory, this allows children with autism to choose the pace and focus of change themselves, thus enabling joint attention to be instigated by children rather than adults, as well as increasing the children’s autonomy under the very favourable conditions of the playroom. In addition, both non-directive play therapy’s emphasis on children and adults’ emotional responses, and therapists’ skilled use of empathy to enter children’s unique inner worlds essentially target areas of development in which children with autism have serious deficits.

Acknowledgements: Orit Josefi is grateful to ‘John’ and to his parents, who gave permission for her to carry out play therapy and research with their child. She also thanks his school, and particularly his head teacher, who was willing to try a new approach in addition to the school’s well-established behavioural and educational programme.

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The case study presented in this article of non-directive play therapy with a 6-year-old boy was based on the theoretical premises described earlier and is therefore exploratory in nature. Its pioneering methodology and practice is presented here as an initial exploration of the feasibility of non-directive play therapy for children with autism.

Several key questions were examined.

1. Was the development of autonomy in the child encouraged during non-directive play therapy?
2. Was the young child able to enter into a therapeutic relationship with the therapist? If so, in what way and how did it affect the child’s behaviour and ability to learn and develop?
3. Was the child’s ability to play symbolically developed during intervention?
4. Did other emotional and/or developmental needs surface during therapy?
5. Were the child’s obsessive/ritualistic activities reduced during therapy?

Case study

Background

‘John’ was 6½ years old when his play therapy with the first author began; his family comprised his parents, an older sister and a younger brother. John had been diagnosed with autism and given a statement of special educational needs when he was 2½ years old. Before beginning her play therapy, the therapist met with John’s mother and then his teacher to gather background information and identify his current developmental level of communication, cognition and play. Since age 5, John had been attending a special school for children with autism where a behavioural–educational approach was followed. The mother and school agreed that John used no verbal language and had limited use of Makaton sign language (vocabulary of fewer than 10 words). John’s communication with others was mainly through gestures and physical guidance of the person to the object he wanted. He had outbursts of energy, running around clapping his hands and screaming, and had occasional tantrums. Finally, John was reported not to play in any way with his brother or other children; his rare play with toys was always mechanical.

These reports from John’s mother and school fit the information the therapist had obtained herself from her earlier, unstructured observations of John at home, and a few observations at school a year earlier. Her observations were for an hour a week over an 8-week period, and formed part of her initial training as a non-directive play therapist. She followed the Tavistock method of observation, with the observer quietly viewing the child, rather than becoming actively engaged (Miller, Rustin, Rustin, & Shuttleworth, 1989). Towards the end of this observation period John had begun initiating contact and rudimentary social interactions with her. These social exchanges built up to John bringing the therapist a clean nappy to put on him in one of her final observations. This action of John’s was highly surprising to his mother. She was emotionally moved by John’s interaction with the therapist and stated that John had previously reserved this task exclusively for her to perform. John’s mother added that all of the social exchanges John had initiated with the therapist were well beyond his social capacities in all previous contexts. This observational method raised exploratory questions itself (to be discussed later) and prompted the therapist to decide to engage John in non-directive play therapy sessions. She hypothesized that her observations, in which she did not attempt to change John, teach him or instruct him, but instead sat quietly and watched attentively, had parallels with the practise of non-directive play therapy, with its focus of joint attention on activities led by the child.

John’s parents agreed to his attending 16 non-directive play therapy sessions of an hour each over a 5-month period. This intervention was the final practicum in the therapist’s
2-year training, in which she received monthly individual and group supervision from the second author, as well as regular written comments on her sessional analyses. (See Ryan & Needham, 2001, for a fuller account of training interventions at the University of York.) The first 12 sessions were conducted weekly, with two 1-week breaks in therapy and one 3-week break, due to school holidays. During the final 2 weeks the last four play therapy sessions with John were held twice a week, due to the pre-arranged time limit for the intervention.

Near the end of these 16 sessions, and because of the child’s deepening relationship with the therapist during the later stages of therapy, his parents were offered three additional sessions for John. These additional sessions were planned to coincide with the end of the school year, thus providing a more natural break for John. They also provided the opportunity for John and his mother to have a highly abbreviated form of filial therapy, a relationship play therapy method that is increasingly practised and researched (Guerney, 2001). John’s mother agreed to attend the final three sessions as an observer; the therapist also helped her understand and carry on with special play sessions after therapy ended, in order to enable John to further extend the changes that he had undergone during therapy into his daily life. John’s mother and the therapist had three meetings during this period, in addition to the scheduled progress meetings after the 6th and 14th sessions. In their meetings they discussed changes in John’s presentation and underlying issues in therapy that would help his mother more easily understand and parent John.

John’s therapy took place at his special school in a medium-sized, white-walled empty room with big windows. In keeping with usual non-directive play therapy practice, the same materials were brought to the room and set up in the same way each time, thus providing children with opportunities to familiarize themselves quickly with the setting (Ryan & Wilson, 1995). The materials were selected for their expressive, imaginative, relaxing and interactive properties (e.g. poster paints, finger paints, play dough, face paints and a mirror, a sand box with sand toys, soldiers, musical instruments, soft toys, baby dolls, baby bottles, puppets, dolls’ house, telephones, a ball, animals, and a farm, pretend food, cars and a few books). Two biscuits and a drink were also provided every session. All of these materials were similar to those in other playrooms (Axline, 1947; Wilson et al., 1992). It is noteworthy here that nothing was altered because of the special needs of children with autism. Materials largely within a 6-year-old child’s normal developmental level, along with materials affording regressive and more advanced play, were chosen.

**Method of analysis**

The case study presented later concentrates on analysing John’s 16 sessions of play therapy. The observations of a year earlier and John’s three sessions with his mother were excluded from formal analysis, because each introduced their own new set of conditions. Both of these latter aspects are, however, referred to later in our general discussion of this case, as are the changes in John described anecdotally by his mother during progress meetings. All of these facets of the intervention give a more complete picture of the internal changes John seemed to have undergone over the entire intervention period.

Video recordings were made of John’s therapy sessions using a semi-static camera. (Note that recording limitations prevented the measurement of his eye contact with the therapist.) Both subjective and objective measures of analysis were used. Exploratory studies of therapeutic change often choose to combine objective and subjective measures into a more comprehensive analysis (Mason, 1994). This combined analysis provided a numerical basis for therapeutic changes, as well as capitalizing on subjective analysis, which can potentially give more detailed insight from the therapist’s viewpoint into the process of change (Boston & Lush, 1994).
The subjective analysis of this case was based on an in-depth qualitative analysis describing the changes in John over his 16 individual play therapy sessions; themes were employed as coding devices to sort, summarize and synthesize observations made out of the more discrete data of each session (Charmaz, 1983). The therapist viewed the video recordings at the end of each session and wrote detailed notes containing as little interpretation as possible. Next, the therapist developed analytical concepts from the observation notes, basing them on more abstract meanings in the data and on theoretical grounds. (This procedure follows Schatzman & Strauss, 1973, who emphasized separation of observational notes from theoretical notes and the drawing of theoretical inferences from the data on an ongoing basis during data collection.)

For the case study's numerical analysis, both the therapist and an independent, trained observer classified the video recordings using set categories derived from the initial questions of the study. The independent results were compared and differences reworked until all results tallied. Each of the statistical measures used was then matched with one or more themes, with the exception of the nurture theme, which was broader and not easily supported statistically here. Because it seemed to represent an important theme for the child, nurture was described as part of the qualitative analysis only.

Five categories of John’s behaviour and activities in therapy were selected for the numerical analysis. The measures were developed to enable comparison of results with the study's overall questions and with the themes developed in the subjective analysis. These categories were:

- child-initiated physical contact with therapist;
- child-initiated play activities, and excluding ritualistic behaviour with objects/toys;
- time spent by child on play activities, including a breakdown by specific activities;
- child-initiated interaction with therapist, including mutual play, smiling, talking and gesturing (eye contact was omitted, as discussed above);
- time spent by child on ritualistic/obsessive activities, including any autistic behaviours, such as tapping the ball, running up and down the room, hitting the ball aimlessly and clapping (time the child spent looking out the window was excluded, as it seemed to serve the function for John of self-regulation of his feelings).

For the qualitative analysis, clear and recurring themes emerged and were used as markers of the child’s progress during therapy. The four identified themes were as follows.

**Attachment:** This theme reflected the child’s ability to enter into a therapeutic relationship and the quality of the bond over the intervention period. The behavioural, numerical measures chosen to link with this theme were ‘physical contact’ and ‘child-initiated interaction with therapist’, to identify whether there were increases in the child’s proximity seeking, interest sharing and/or social interactions with the therapist.

**Autonomy:** This theme reflected changes in the child’s autonomy through his choice of activities and self-initiated movement in the playroom and in the immediate environment outside the playroom. The behavioural measure of ‘activities initiated by the child’ supported this theme.

**Symbolic play development:** This theme identified changes in the quality of the child’s play, from solitary to more complex social play. The child’s level of enjoyment of play and social interaction are also discussed under this heading. The behavioural measures of ‘time spent on play activities’ and ‘time spent on ritualistic/obsessive activities’ supported this theme.
Nurture: This theme represented changes in the child’s activities of physically nurturing himself and of playing out nurturing experiences symbolically. No behavioural measure was developed to support it.

Findings

The findings of the qualitative analysis of each theme are presented first, followed by their associated, behavioural measures. These are followed by a summary of the changes in John reported to the therapist by his mother at their progress meetings.

Attachment

This theme reflected the therapist’s perception of how safe John felt in the playroom with her. His level of security often seemed to be indicated by his body’s positioning in relation to the therapist, the quality of their social interactions, and the way he handled a soft ball in the room. He appeared to use the ball as a transitional object to enhance his emotional security. During his initial therapy sessions, John spent the majority of his time standing at the other side of the room looking out of the window. He was physically distant from the therapist and initiated minimal eye contact. As therapy progressed he increasingly spent time in close proximity to the therapist, initiating both eye and physical contact. His time at the window was increasingly brief. John’s social interactions with the therapist also increased during the course of the therapy, starting with improved eye contact and progressing to increased communication with her using gestures and words. John’s initiations of increased and more intense physical contact included climbing onto her lap and requesting a piggyback ride after the end of their later sessions together.

John’s use of the soft ball changed significantly during his 16 play therapy sessions. During the first three sessions he kept the ball with him at all times as he explored the room and the therapist. By the fourth session his continued holding of the ball had lessened and he seemed to feel more secure. John began initiating playful passes of the ball between himself and the therapist, after she had run alongside him repeatedly as he bounced the ball in earlier sessions. Indeed, by his 15th session John seemed very aware of the therapist’s rules in the playroom and seemed to deliberately make a great effort to throw the ball out of the window. This increase in autonomy, discussed more fully later, could also be interpreted as a new stage in his level of emotional security. On another occasion during a later session, when John had hurt his hand, he immediately sought out the therapist for comfort.

This evidence seemed to indicate that the therapist (and the room) had come to represent security for John and that he had managed to establish an attachment with the therapist. His attachment appeared to have similarities to that of a young child with his primary carer. This interpretation of their relationship was further supported by John’s reaction to the therapist in the sessions prior to separation for holidays. He appeared to display normal loss reactions and seemed upset with the therapist for leaving him. His attachment response was underlined prior to his 12th session, when his teacher mistakenly told him that the therapist was not coming for him that day. (Both his mother at home and his teacher at school always reminded John in the morning of his upcoming session.) After this news, John burst into tears and was inconsolable for a time.

The objective measures of ‘physical contact’ (Table 1) and ‘child-initiated interaction with therapist’ (Table 2) link with this attachment theme. The number of times John initiated physical contact during each session and the total length of time he physically touched the therapist are shown in Table 1. Clearly, in sessions 11–14 he initiated the most physical contact as well as being near the therapist longest.
Autonomy
The child’s level of autonomy was reflected for the therapist in John’s need for help, the way he managed playroom rules and boundaries, and the development of his curiosity and exploration of his surroundings. At the start of therapy John needed the therapist’s help with basic tasks, such as taking the cap off the baby bottle and taking the lids off the play dough containers. As therapy progressed, he seemed more confident and autonomous, rarely indicating that he needed help and he seemed quite determined to do things by himself. For example, during the 10th session when John tried to open the sack containing the building blocks for the first time, it took him several minutes to find a way to open it, but he persisted, with the therapist reflecting his feeling of determination, until he succeeded.

Turning to the playroom rules and boundaries, as early as the second session John began testing the therapist’s limits, mainly by his refusal to leave the room. From the eighth session, however, his testing of the limits was more proactive and intentional, reminding the therapist of young toddlers starting to develop their own will, including testing it against an adult’s will. (For a full discussion on the development of autonomy, see Wilson et al., 1992, Chapter 5.) This behaviour became prominent for three sessions, but eased off from the 11th session onwards. John then seemed more able to regulate his willfulness. However, during the 15th session, perhaps as a response to the ending of therapy and/or to this session having followed a half-term break, he returned to more prominent rule testing during the therapy hour.

As John’s autonomy grew, he appeared more inquisitive and freer in his activities both inside and outside the room. In the room he began exploring more toys that he seemed unfamiliar with, such as the pretend food, looking for ways to play with it and with the dolls’ bottles. At times, when John decided to leave the room for the toilet, instead of returning immediately, the therapist found him looking around the other rooms on the same floor. He appeared very curious to discover his environment and showed the confidence of a child willing to explore areas further away from his secure base.

John’s social interactions with the therapist over the course of therapy are represented in Table 2. It is evident that there was a dramatic increase in his level of interaction, particularly in the areas of physical contact and play. Table 2 also shows that his requirement for help from the therapist had decreased, thus supporting the subjective analysis by the therapist of his increased autonomy.

The objective measure of ‘activities initiated by the child’, set out in Table 3, offers additional support for the therapist’s subjective analysis of John’s increased autonomy. Table 3 illustrates that he initiated more activities in the room as his sense of autonomy seemed to grow stronger.

Play
The development of this theme was explored by examining John’s choice of activities, his level of engagement in these activities, his interaction with the therapist, and his level

Table 1. Physical contact

<table>
<thead>
<tr>
<th>Session</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>15</th>
<th>16</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of physical contacts</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

| Total time of physical contact | 0 | 0.12 | 0.95 | 0 | 0.08 | 0.97 | 0 | 0 | 0.12 | 0.17 | 1.33 | 5.67 | 6.42 | 4.83 | 2 | 1.5 |

1 Time is in minutes taken from the hourly session.
of concentration in his play. Until the ninth session, John’s play was very much the same in every session, with only small variations. He used the poster paints, finger paints, play dough and musical instruments. From the ninth session onwards, John still used all these activities, but he also began to engage in other activities with toys that had a pretend play quality to them. He first gave his attention to the pretend food, then the building blocks, baby dolls, toy phones and doctor’s kit. Table 2. This play seemed to be a very significant change because John had begun engaging in the appropriate use of these pretend toys.

The new activities John chose to engage in from the ninth session onwards also affected his social interactions with the therapist, with a significant increase in mutual play. The building block activity, the play with the pretend food, the feeding of the dolls, and use of the toy phones were all activities that involved the therapist as a full participant in his play. This was very different to the activities he chose during the first part of the therapy, which were all solitary play activities, and allowed no space for the therapist to participate. During John’s later activities involving the therapist, he appeared to experience real pleasure; his feelings of fun were communicated by smiling and laughing.

Table 2. Time spent in interaction with therapist

<table>
<thead>
<tr>
<th>Session</th>
<th>1</th>
<th>2</th>
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<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>15</th>
<th>16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Talked to therapist</td>
<td>0.58</td>
<td>0.17</td>
<td>0.08</td>
<td>0.15</td>
<td>0.50</td>
<td>0.67</td>
<td>0.20</td>
<td>0.03</td>
<td>0.03</td>
<td>0.37</td>
<td>0.03</td>
<td>0.67</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asked for help</td>
<td>0.03</td>
<td>0.03</td>
<td>0.03</td>
<td>0.03</td>
<td>0.03</td>
<td>0.03</td>
<td>0.03</td>
<td>0.03</td>
<td>0.03</td>
<td>0.03</td>
<td>0.03</td>
<td>0.03</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initiated interactive activities</td>
<td>1.92</td>
<td>0.58</td>
<td>1.50</td>
<td>0.17</td>
<td>1.83</td>
<td>0.05</td>
<td>0.58</td>
<td>6.00</td>
<td>2.42</td>
<td>9.08</td>
<td>12.00</td>
<td>8.85</td>
<td>5.92</td>
<td>3.17</td>
<td>5.33</td>
<td></td>
</tr>
<tr>
<td>Communicated with gestures</td>
<td>0.02</td>
<td>0.02</td>
<td>0.03</td>
<td>0.05</td>
<td>0.33</td>
<td>0.23</td>
<td>0.17</td>
<td>0.03</td>
<td>0.17</td>
<td>0.28</td>
<td>0.33</td>
<td>0.83</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Broke boundaries/looked for a reaction</td>
<td>0.03</td>
<td>0.17</td>
<td>0.28</td>
<td>0.33</td>
<td>0.33</td>
<td>0.33</td>
<td>0.33</td>
<td>0.33</td>
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<td></td>
</tr>
<tr>
<td>Asked for comfort</td>
<td>0.67</td>
<td>0.08</td>
<td>0.17</td>
<td>4.33</td>
<td>0.13</td>
<td>2.33</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initiated physical contact</td>
<td>2.53</td>
<td>0.22</td>
<td>1.38</td>
<td>1.53</td>
<td>0.31</td>
<td>1.86</td>
<td>0.25</td>
<td>1.25</td>
<td>7.12</td>
<td>2.42</td>
<td>9.61</td>
<td>16.36</td>
<td>9.57</td>
<td>9.78</td>
<td>3.20</td>
<td>6.17</td>
</tr>
</tbody>
</table>

1 Time is in minutes taken from the hour session.

Table 3. Time spent on activities initiated by the child

<table>
<thead>
<tr>
<th>Session</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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<th>13</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Sand</td>
<td>0.83</td>
<td>3.00</td>
<td>0.50</td>
<td>1.58</td>
<td>0.58</td>
<td>1.17</td>
<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Musical Instruments</td>
<td>0.83</td>
<td>1.00</td>
<td>1.50</td>
<td>1.00</td>
<td>1.92</td>
<td>0.68</td>
<td></td>
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</tr>
<tr>
<td>Book reading</td>
<td>1.92</td>
<td>1.50</td>
<td>1.33</td>
<td></td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Play dough</td>
<td>0.30</td>
<td>1.75</td>
<td>2.67</td>
<td>3.17</td>
<td>3.58</td>
<td>1.92</td>
<td></td>
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1 Time is in minutes taken from the hour session.
His social interactions with the therapist became decidedly more intense; John often imitated her actions; and when they played together, he initiated interactions involving the therapist having joint attention of the toys with him.

For example, when they played with the building blocks, John initiated taking turns in holding the tower and building it. Furthermore, the first few times they played together, John chose to build towers made from blocks of the same shape and colour, and the therapist followed his pattern. The therapist then used the child development principle of moving inside the child’s zone of proximal development, when John seemed competent with this block play. She started extending his play slightly by introducing towers built of mixed shapes and colours and surprisingly, he participated by adding blocks to the tower randomly, thus leaving behind his ritualized activities during this interaction. Figure 1 compares the average total interaction time between John and the therapist in the first eight sessions and the last eight sessions; Figure 1 shows a large increase in the total length of social interaction with the therapist between the first and the second part of therapy.

Returning to Table 3 which represents the activities initiated by John, the table shows the kind of play John chose to engage in over the period of therapy, and supports the therapist’s subjective findings on John’s changes in play activities. It shows not only the change in John’s choice of play activities, but also the increase in the number of activities he engaged in and the change in his concentration level over time.

John’s level of concentration changed during therapy; in early sessions while he was playing, John often stopped to tap his ball or clap his hands for a few seconds before returning to his play activity. Towards the end of the therapy he was able to sit quietly for 15 minutes or more and engage in a play activity, without engaging in any ritualistic behaviour. During these activities John seemed relaxed and happy; at times he looked up to either smile at the therapist or initiate social interactions with her.

The objective measure, ‘time spent on play activities’ (Table 3, Figure 2), gives further information on John’s concentration level and quality of play over time.

Looking at his engagement in messy play, for example, in the first eight sessions he spent the most time on messy play activities, such as play dough activity, finger paints and painting with brushes, with his enjoyment of finger painting standing out. In comparison, looking at the last eight sessions, John’s average concentration level increased and, with regard to the finger painting, it doubled. John’s enjoyment of messy play was particularly surprising; his mother initially had informed the therapist of her son’s dislike of touching messy things, such as sand; to her knowledge he had never used finger paints before therapy commenced.

Another finding shown in Table 3 concerns the total time John spent playing each session. Even though there were irregularities, there was an overall upward trend.
Looking at the first and final sessions, John was engaged in play for 5.8 minutes in the first session and 28.25 minutes in the last. Furthermore, the average total time spent on self-initiated activities in the first eight sessions is 11.2 minutes, whereas the average in the last eight sessions is 21.22, an increase of 81%.

The measure of ‘time spent on ritualistic/obsessive activities’ (Table 4) was designed to give a balanced picture of John’s progress in his play activities in comparison with time he spent acting ritualistically.

When looking at the first and the last session (Table 4) there is a decrease from 15.25 minutes to 6.17 minutes. However, this does not give a true representation of the change; the average for the first eight sessions and the last eight sessions, as illustrated in Table 4, gives a truer picture, suggesting a less major decrease in the time John spent in ritualistic activities or behaviour. The average was 10.89 minutes in the first eight sessions compared with 8.39 minutes in the last eight sessions, a decrease of 23%.

**Nurture**

This theme was developed first in the use John made of the biscuits and drink provided and later by pretend play with food. West (1996) suggests that ‘Food is a basic essential that symbolically conveys valuing and caring, as well as having practical nutritional aspects . . .’ (p. 75). John’s need for nurture was prominent in his sessions; he always started his sessions by eating the biscuits provided, sipping water from the baby bottle and drinking from his juice. Initially, he appeared to compulsively eat the biscuits – he pushed them into his mouth as if he was desperately hungry – and he tended to sip from his juice throughout the session, while still ensuring that he had juice left in the carton to take back to his classroom. When John played with the finger paints, which seemed to be a soothing and self-nurturing activity for him, he piled more and more paint on the
paper, as if no amount of paint was enough for him. This issue of experiences and substances not being enough for him was mirrored in his refusal to leave the playroom during the first five sessions of therapy when his hour was up.

From the sixth session John’s attitude appeared to change: (i) he began taking his time eating the biscuits and seemed to enjoy every little bite; (ii) from that session onwards he finished drinking his juice in the playroom and did not take it with him back to his classroom; (iii) when he played with the finger paints he did not use too much paint; and (iv) he seemed more accepting of the end of the sessions. These changes seemed to indicate that he had begun to more easily regulate his need for nurture within the playroom.

A turning point in therapy appeared to occur during John’s ninth session; for the first time John asked for more biscuits. This seemed highly significant; he was able to state his need for more and ask the therapist, with whom he seemed to be continuing to develop a substitute attachment relationship, to meet his need. Because one of the rules in the playroom was that he could have only two biscuits per session, the therapist introduced pretend food to him instead. Initially, when the therapist offered him the pretend biscuits he smelled them, tried to bite them and then threw them back in their box in disgust. But the third time they were offered to him in response to his repeated requests for more biscuits, John began to accept them and play with them. He held out a plate for the therapist to put on the pretend biscuits and other pretend food, each time examining and smelling them before placing them back on the plate. His recognition that his physical needs were being met, his strong need for nurture, and several other conditions of the playroom environment, discussed further later, seemed to be preconditions for the beginning of his engagement in pretend play. John first engaged in symbolic play with the pretend food and later extended this play under his own initiative to feeding the baby dolls with his baby bottle.

These examples show that the theme of nurturing in John’s play therapy sessions overlaps with his other themes of attachment, autonomy and symbolic play development. No specific objective measure was developed to support this nurturing theme in this exploratory case study.

Changes in John reported by his mother
The changes in John at home, informally reported to the therapist at the last progress meeting with his mother, supplement the earlier findings from his play therapy sessions. The following changes were detailed.

At the start of therapy, John was not dry at night. He was dry at night by the end of the 16 sessions and also had stopped drinking his bottle at night.

While attending therapy sessions John had started to go to respite care overnight (once a month) and his mother was quite surprised that he accommodated to this change quickly.

John now seemed better at anticipating routine events, in coping with changes in his routine and in expressing his needs/wants to her.

Unlike before therapy began, John seemed to accept his mother’s rules more and needed them stated only once to comply. She gave an example of a time when he played in the small pool on their balcony and asked for an apple. She told him he could have an apple, but that he could eat it only while sitting on the side of the pool. Even when his mother went back inside the house, John remained seated on the side eating his apple and did not attempt to break that rule, as he would have done in the past.

John was reported to be more emotionally responsive. His eye contact was much better than at the start of therapy, and at times he seemed to notice other people’s needs,
which he never had done before. His mother related a recent incident when they, as a family, went to the park and John’s ball fell into the water. His father tried to rescue the ball and John followed him, balancing himself behind his father. Next John’s younger brother followed, but found it difficult to climb to where John and his father were standing. John’s mother, with strong emotion, described John suddenly, and without being asked, extending his hand to his brother and helping him to climb, to the complete astonishment and disbelief of his parents.

Discussion

The questions posed at the beginning of this article on the viability of non-directive play therapy for children with autism are discussed in light of the findings reported earlier. The following discussion acknowledges the limitations inherent in generalizing from a single case because the autistic spectrum is composed of varied subgroups and children with autism frequently have other diagnosed problems and variations in their abilities (Blakemore-Brown, 2002; Wing, 1996). First, one of the defining features of non-directive play therapy is that children choose their own focus of interest and own pace of change. This case study explored whether autonomy in a child with autism could be enhanced through the use of a non-directive play therapy intervention. This non-directive method was of interest because a lack of autonomy is often noted in the literature, yet remains under researched. Children with autism often frustrate adults’ attempts to interact with them by their remoteness and by their not taking any initiative in social exchanges. Indeed, research has shown that mothers can react to their children’s lack of autonomy by becoming more directive (Trevarthen, Aitken, Papoudi, & Robarts, 1998).

For John, the findings showed an increase in his autonomy over the course of therapy. He became more able and willing to do things for himself without requiring help from the therapist. As indicated in Table 2, John asked for help only in his first five sessions; this finding was supported by the therapist’s subjective analysis that John developed more independence as therapy progressed. The findings also support his increase in initiative. From Table 3 it can be seen that there was a marked increase in the number of activities in which he engaged. Although John’s play involved the same activities in the first 9 sessions, from his 10th session onwards he began to initiate play involving new activities. Table 3 shows that there was an increase from 8 to 12 activities in the last six sessions of therapy.

Finally, over the course of therapy John went through a process of challenging the rules and boundaries of the therapeutic environment. This process appeared very similar to the behaviour of a 2-year-old child when starting to discover his own will, along with learning mutual limitations of wills (Wilson et al., 1992). Towards the end of therapy, John seemed to have developed emotionally to the point of being more accepting of the boundaries set in the playroom. These gains were also reported by his mother in his home environment. It seems likely that John’s non-directive play therapy worked as a catalyst for him in the development of his autonomy and initiative. Therefore, this single case study is important in suggesting that a method of therapy that is non-directive in essence may counteract the lack of autonomy and lack of initiative in children with autism, and enhance their development. It also suggests that, for John, his development of autonomy and initiative, although delayed, did follow a general pattern expectable in younger children without autism.

Findings of this case study also informed the second initial question, whether a child with autism would be able to enter into a therapeutic relationship, and, if so, whether this relationship would affect the child’s behaviour and ability to learn. Similarly to
Sigman and Ungerer’s study (1984), John demonstrated that he was capable of forming a substitute attachment relationship with the therapist (Heard & Lake, 1997). This attachment relationship appeared to have begun during the therapist’s initial observation period a year earlier, when she quietly observed and remained attentive to him. In this context, the hypothesis advanced by Richer (2002), following the Tinbergen’s, that many behaviours of autistic children can be viewed as fear responses, has relevance to how John began to form an attachment relationship with the therapist. She remained interested, but unthreatening, during both her observations and her later play therapy by allowing John to determine the focus and pace of change. The therapist therefore seemed to lower John’s fearful responses to her dramatically, thus providing opportunities for him to initiate approaches to her for comfort, nurture and exploration of his internal and external environments.

John’s deepening attachment to the therapist is evident in both the objective and subjective analyses presented here. His reported distress when told by his teacher that the therapist would not come as planned was similar to the expected reaction of a child separated from an attachment figure. Other attachment behaviours reported in the therapist’s subjective analysis were John’s coming to her for comfort when he had hurt his hand, climbing into her lap for soothing and his piggyback rides after the therapy hour had ended (Bowlby, 1988). The objective measure of physical contact, given in Table 1, shows a significant increase in the number of times John initiated physical contact with the therapist, and also an increase in the duration of physical contact over the course of therapy. Table 2 also shows a dramatic increase in John’s interaction with the therapist, mainly through physical contact and dyadic play. Comparing the first and last eight sessions, there was an eight-fold increase in his interactions with the therapist.

The attachment findings for John are in agreement with the findings of Rogers, Herbison, Lewis, Pantone, and Reis (1986) in their study of young children with autism and severe emotional handicaps. They suggest that the improved social interaction they witnessed in their study had been promoted by the growth of a strong relationship between the adult and the children involved. John’s apparently secure attachment relationship with the therapist, begun over the 8-week observation period and developed over their 5-month period of play therapy sessions, suggests that non-directive play therapy may offer the right conditions for children with autism to form therapeutic relationships. Which aspects of the therapeutic relationship, of the therapist herself, of the therapeutic alliances forged with home and school by the therapist, and of the initial, non-threatening but attentive, observation period, contributed to the outcomes of therapy for John cannot be answered by this single case study. Non-directive play therapy itself may provide children with autism, similarly to children who have other emotionally troubling issues in their lives, with: (i) emotional security and relaxation, (ii) an enhanced and attentive adult environment in which playing together is emphasized, and (iii) the acceptance by therapists of children’s ability to instigate therapeutic change for themselves under favourable conditions. These conditions have been identified as providing the basis for therapeutic progress in the play therapy literature (Axline, 1947). These same conditions were identified by Bowlby (1988) as necessary for forming secure attachments.

The case study findings also inform the question of whether non-directive play therapy enabled a child with autism to play symbolically. Both subjective and objective measures showed an increase in and development of John’s play over the course of therapy. The time he spent playing increased significantly (see Table 3), his repertoire of play activities expanded and he was able to concentrate for longer. John’s choice of play activities also altered. Towards the end of therapy he appeared to be seeking activities that offered
more joint attention and direct social interactions with the therapist, such as building blocks. During that time his interest in toys that had symbolic qualities to them (e.g. dolls’ house and bottles, toy phones) began to emerge. These findings lend support to Hobson (1993) and Mundy, Sigman, and Kasari (1993), who hypothesize that engagement in joint attention with others contributes to the development of symbolic abilities in children. The findings also support the detailed hypotheses of the second author, who suggested seven essential features as preconditions in children, including those with pervasive developmental delays, for the development of symbolic play. These features include:

1. **Routine social exchanges with a carer based on reciprocal roles.** Research on mother–infant social exchanges show how mothers help infants to change more basic infant–object interactions and infant–carer interactions into more complex infant–carer–object interactions. And these established routines often become familiar and sociable games together, as mothers extend their responses to encompass their children’s ‘zone of proximal development’.

2. **The use of concrete symbolic objects from real-life situations.** An object highly similar or identical to a real-life object may be needed to evoke rudimentary symbolic play (e.g. John’s pretend biscuit).

3. **Children’s affective involvement in play activities.** Children’s own needs and interests seem to be the jumping off point for children to vary and organize their actions and thinking; this primacy of affect/motivation seems crucial during normal development (e.g. John wanting another biscuit).

4. **One-to-one intensive, regular social support.** Children need to have more advanced play partners modulate their own activities to suit children’s interests and capacities.

5. **Relaxation and the satisfaction of children’s physical and security needs.** In order to develop symbolic play children may need a familiar, safe environment where they trust that their physical and security needs are met and that they will continue to be met in the future.

6. **The cognitive capacity to symbolize on a rudimentary level.** The cognitive capacity to allow one object to stand for another, which usually begins to emerge at 12–18 months of age, seems needed, along with sufficient knowledge of objects to be used symbolically.

7. **Specific social learning about play.** One of the most essential forms of knowledge that seems needed is for children to realize that certain situations are both ‘pretend’ and enjoyable, including marking out certain activities as ‘pretence’. (See Ryan, 1999 for a fuller discussion.)

Another important precondition for the emergence of symbolic play may be engaging in sensory-motor play (Hellendoorn, 2001, personal communication). Sensory materials – for example, food – when used in non-functional ways (e.g. spaghetti hoops placed on their fingers when toddlers feed themselves) may stimulate the perceptual, motor and neural development needed for one object to represent another (e.g. spaghetti hoops coming to symbolically represent finger rings for a child). These experiences of play occur naturally for younger, normally developing infants (Piaget, 1952) but often develop with greater difficulty in children with disabilities and in children who are multiply deprived and maltreated. For children with autism, early markers include lack of pretend play, of joint attention, and of social interest and social play (Baron-Cohen et al., 1996). Enhancing these children’s early patterns of interactions with carers by employing the above features of rudimentary symbolic play, as the therapist did with John in non-directive play therapy, seems to merit further research.

All of these preconditions for rudimentary symbolic play were present in John’s play...
therapy sessions. The first ever instances of John playing symbolically emerged in his play therapy sessions, possibly because he had been provided with the ideal conditions for the development of this largely innate capacity. This symbolizing capacity has similarities to and overlaps with children’s capacity to learn language during normal development. And language learning also seems to require most of the essential conditions hypothesized earlier for the development of symbolic play. In this context, during the second half of his play therapy, John became more vocal and more communicative towards the therapist. He appeared to be trying to say words, although they were often difficult for the therapist to comprehend. This aspect of the intervention was not investigated systemically. However, it may be of significance for future research on the overlap between the capacity and prerequisites for symbolic play development and the symbolic development required for language learning. Improvements in basic symbolic play or in rudimentary language learning may contribute to the development of the other function systematically. For children with autism this seems especially relevant, as their language loss frequently is one of their most serious cognitive impairments and affects their level of ability to play (Trevarthan et al., 1998).

The fourth question was whether non-directive play therapy would enable the identification of other emotional needs in a child with autism, as the child himself determines the focus of treatment. In John’s therapy sessions his need for nurture was a strong and recurring theme. One way John expressed this theme was through his strong fascination with messy play in general and finger painting in particular. Table 3 shows that messy play activities were consistent choices and that his concentration level during these activities was very high in comparison with other activities. According to his mother, John had not experienced messy play prior to therapy. This raises questions concerning other activities and experiences denied to children with autism, as alluded to earlier, due to their unexpected behaviour and the anxieties these behaviours evoke in the adults caring for them. Adults who generally feel insecure about their ability to contain and predict such children’s behaviour may be reluctant to offer messy activities to them.

This point is related to Mundy and Crowson’s (1997) suggestion that the symptoms of autism may reflect not only the outcome of an initial neurological disturbance, but also the ongoing environmental processes that in turn affect these children’s development. In non-directive play therapy, children are free to act according to their actual developmental stage and to choose play activities accordingly. John’s choice of messy play activities repeatedly suggests that, in addition to issues of messiness perhaps mirroring his feelings of internal chaos, his need for sensory play may not have been met adequately earlier, delaying his development in this area significantly.

The final question explores whether non-directive play therapy affected the obsessive/ritualistic activities of a child with autism. The findings indicated only a minor reduction in John’s ritualistic behaviour. It would, therefore, be impossible to draw conclusions about any effect the therapy may have had on this aspect of his behaviour. However, it is interesting that during the 12th session, when John spent the longest time playing appropriately, he also spent the least time engaged in ritualistic behaviour. This case study raises the possibility that play fulfils the same purpose for children with autism as self-stimulation; on the other hand, it may be that play is simply a competing behaviour. Wulff (1985) claims that some of the stimulatory behaviours of children with autism temporarily decrease in the presence of appropriate play. More research on the relationship between appropriate play and obsessive activities may, therefore, provide clues to the purpose of hand flapping and other self-stimulatory activities, so common in the behaviour of children with autism.

A finding that emerged from this case study was that the objective measures showed
marked differences between the sessions offered twice a week (sessions 11–14), compared with those offered once a week. In the twice-weekly sessions all five areas of behaviour measured numerically showed a dramatic shift in comparison with the rest of the intervention period. For example Table 3 shows that until the 11th session, the average total time spent on play was 11.86 minutes, while the average time from the 11th session onwards increased to 23.46 minutes, an increase of 98%. John's interaction with the therapist also increased significantly, from an average of 1.89 minutes per session to 9.12 minutes per session from the 11th session onwards. The average per session during these twice-weekly sessions was 11.33 minutes, a dramatic increase in John's interaction with the therapist. The only measure that did not demonstrate a dramatic shift was John's ritualistic behaviour. Although the time John spent on ritualistic activities decreased from the 12th session onwards, the findings showed only intermittent improvement throughout the intervention.

Tentative inferences can be drawn from the changes shown by John during twice-weekly sessions. First, more frequent play therapy sessions coincided with more frequent changes in John's behaviour during his play therapy sessions. This may be due to a cumulative effect, with later therapy sessions producing more changes in his behaviour in the playroom. And/or it is possible that twice-weekly sessions may have been more effective in producing changes in John's presentation than once-weekly sessions. Either possibility seems to imply that in John's case his behavioural changes were more rapid with increased exposure to non-directive play therapy sessions. Therefore, it is more likely that the changes in his behaviour were due to non-directive play therapy rather than to other factors.

**Implications for practice and future research: Non-directive play therapy and behavioural treatments**

Behaviour therapy, as mentioned initially, is the most frequently used therapy for children with autism; it appears effective in reducing the frequency and severity of their symptoms (i.e. their ritualistic/obsessive behaviour) and in increasing their development of adaptive skills (Connor, 1998). Research also implies that this method is not as effective in the areas of initiating joint attention, gaining autonomy or developing social and symbolic play (DeGangi, Wietlisbach, Goodin, & Scheiner, 1993; Rusmussen & Cunningham, 1995). Interestingly, this case study has shown that non-directive play therapy was weaker for John in the areas where behaviour therapy appears effective, but effective for him in the very areas where behaviour therapy is least effective. In particular, although behaviour therapy seems effective in reducing children's obsessive behaviour, in John’s case play therapy had a patchy effect on his ritualistic behaviour. For John, non-directive play therapy appeared effective in developing his autonomy, initiation of joint attention, concentration, enjoyment, interaction with the therapist and in the development of symbolic or pretend play. While these findings are limited to a single case and therefore exploratory rather than definitive, they are very encouraging. They offer the possibility that non-directive play therapy could be utilized in parallel with behavioural methods, as John experienced in school and at home during his play therapy sessions, thus offering a more holistic treatment for children with autism.

**Conclusion**

Single case studies are well known as a rich source of information and hypothesis formation, thus serving a seminal role in generating more rigorous and extensive research. Indeed, as Howlin (1998) points out, Kanner’s early writing on autism consisted
primarily of a collection of single case studies. This case study has found that non-directive play therapy may have particular and significant benefits for children with autism. In order to investigate whether the results achieved in this exploratory study can be replicated, research on a larger scale is required.

Areas to investigate include:

• Can non-directive play therapy be effective only in conjunction with behavioural therapy or can it be effective as a stand-alone treatment?
• What is the optimal frequency of sessions?
• What is the optimal duration of therapy? (The Lovaas programme, for example, requires intensive one-to-one training for 40 hours weekly over 2–4 years.) What could be achieved with a more intensive non-directive play therapy programme than the limited one provided in this study?
• What role can carers play as therapeutic change agents for their children? That is, to what extent can filial therapy (Guerney, 2001; Guerney & Guerney, 1994), a relationship play therapy based on carers being trained in basic non-directive play therapy skills, be utilized for children with autism?
• What role can observation serve in developing a non-threatening, attentive relationship with adults for children with autism?

In summary, the last decade has shown a dramatic increase in research into the treatment of children with autism. However, most research has been in behavioural therapy, because it is both amenable to measurement and seems to be beneficial to these children. As a result, other areas of investigation have been neglected; this study takes the first step in redressing this imbalance for non-directive play therapy. Howlin and Rutter's statement, made several years ago, still holds true today:

[O]ver-reliance on strict behavioural technique has led to a disregard of approaches that [consider] children’s developmental levels and individual differences. It seems that a well-based intervention programme should incorporate developmental as well as behavioural principles.

Alvarez’s (1996) psychoanalytic psychotherapy for children with autism strongly advocates that therapeutic interventions for children with autism need to be attuned to each child’s exact developmental level. This article has attempted to show how a non-directive play therapy approach could automatically operate at a child's current developmental level, and that it is a highly individualized intervention. Children themselves determine the focus and pace of change and therapists are trained to be sensitive to developmental issues in their practice. For John this approach seems to have been highly effective in a short space of time. More research is needed urgently to explore the possible benefits that non-directive play therapy can offer to other children on the autistic spectrum.

References


