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The Inability to Play. Pre-Psychotherapy in Children Who Do Not Play

Noga Levine keini*

Ashkelon Academic College, Israel

***Corresponding Author**

Noga Levine keini, Ashkelon Academic College, Israel.

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Abstract

The central and well-documented role of play capacity in normative development and in interventions with children has been extensively described in professional literature. This paper focuses on conditions in which that capacity is disrupted. I review two characteristic forms of impaired play ability observed in children and subsequently propose - and illustrate - a therapeutic approach intended to facilitate the restoration of play capacity, enabling the child to use the therapy itself as a play milieu (play therapy).

Keywords: Play, Therapy, Impaired play, Case illustration, Role of play

1. Introduction

The use of symbolic play as a necessary function for healthy development and as a primary instrument in child psychotherapy is widely presented in the literature [1]. For Winnicott, play is not merely use of imagination but an employment of imagination as a two-way bridge between the child's internal world and the external world. Play, in Winnicott's view, occurs in a highly particular and hard-to-define intermediate territory between inner and outer reality - where the boundaries of reality are blurred and imagination and reality interpenetrate. Play capacity is not an alternative to reality but serves to mediate between these two worlds, creating a dialogue that promotes adaptation and normal development. It is important to note that a child's ability to engage in "as if" play catalyzes internalization, identifications, and the resolution of conflicts; this process fosters the construction of an autonomous identity and supports individuation [2].

In conditions of severe and persistent psychological stress - what Fain terms "strain trauma" - the bridge between the child's inner world and the external world may collapse, and children may cease to play [3]. Brent identified five dimensions underlying the inability to play; these dimensions encompass broad areas of the child's life and are not limited to stimuli that explicitly recall the child's distress [4]. This impairment commonly produces observable stagnation in the child's overall psychological development - affective, interpersonal, and cognitive. A central characteristic of such states of distress is that the external, previously safe world that formerly permitted the child to play and to experience fears, needs, and wishes is no longer experienced as safe. In such circumstances the boundary between reality and fantasy becomes blurred; everything blends into an undifferentiated, frightening mass, and play becomes impossible [5].

Two Forms of Impaired Play Capacity

1. Silencing of Reality — the 'Pseudo-Play' On a superficial level this presentation may appear as if a rich imaginary play is taking place. However, closer inspection reveals an absence of mediation between imagination and reality; instead, there is an avoidance of reality altogether. Imagination becomes the child's refuge - a defensive bubble protecting against an intolerable external reality. Boles have termed this presentation "the ghost-line personality [6]. This phenomenon resembles, to some extent, the autistic-like imagery described by Testin. The child silences the threatening real world and elevates the imaginary in its place. This is not genuine play but rather ritualized behavior whose outward features mimic play.

2. Silencing of the Imaginary - Overly Practical, Concrete Play In this second style, in contrast to the previous one, the external world is not silenced; rather, the child's internal imaginative life is suppressed. Defensive escape takes the form of preoccupation with concrete, two - dimensional, practical content lacking internal meaningful depth. The concrete representation is treated as the thing itself and nothing more: there is no internal narrative - animals are plastic toys, soldiers are merely figurines, and a drawn animal is "just a picture" with no feeling. This mode of engagement provides no mediation between inner and outer

realities; it constitutes primarily an escape from the internal world. Hence, this too does not qualify as authentic play.

2. Clinical Manifestations of Absent Play Capacity

Although the two forms of pseudo-play differ in external presentation, both reflect the same underlying phenomenon: an impairment in the mediating function between inside and outside, and thus a true inability to play. Notable common features include:

• In both presentations the child's activity during the therapy hour is repetitive, monotonous, and static. There is no developmental progression during or between sessions. The child's behavior resembles a ritual repeated without variation rather than play.

• In both styles the therapist's countertransference commonly includes feelings of stagnation and boredom. In the pseudo-play presentation these feelings may take longer to recognize. Such countertransference indicates defensive dynamics, blockage, and stagnation.

• In both cases the therapist does not feel an authentic personal connection with the child; the child does not appear to genuinely need or use the therapist. This is unsurprising, since the therapist, by role, represents the bridging function between inside and outside - between imagination and reality - a bridge the child is not ready to utilize.

Why a particular child's psychic organization chooses to express the inability to play in one form rather than the other remains an interesting, unresolved question, akin to questions in psychopathology about symptom selection. I do not pursue this issue further here.

3. Treatment - Restoring Play Capacity

The approach I outline focuses primarily on restoring the child's play capacity -what might be termed a "pre-psychotherapy" phase - prior to engaging in in -depth processing of the conflicts shaking the child's psychic world. The goal at this stage is limited and specific: to reactivate the play function. Once the play function is restored and the reciprocal feed between inside and outside reestablished, one may proceed with standard psychodynamic or analytic techniques (as proposed by Winnicott, and Berger and Kennedy, to address deeper conflicts [6-8].

Just as the two forms of absent play differ, so do the therapeutic emphases. The recommended intervention depends directly on which domain the child has silenced.

3.1 Treatment when the 'Reality' Domain is Silenced (the Pseudo-Play)

In the pseudo-play condition, it is initially necessary for the therapist to emphasize the external domain that is inaccessible to the child. This does not imply confronting the child directly with the difficult facts of their life—such exposure would be too overwhelming at this stage, and the child lacks the resources to manage it. One should begin with a graded introduction of the external ("outside") - a dose calibrated to the child's tolerance. The most available option is for the therapist to underline the reality of the therapist's own presence within the therapeutic encounter. When the therapist represents something outside the child yet remains connected to the child, the therapist can progressively limit the place of ritualized, predominantly autoerotic behavior, and remain present alongside the child [9] Bolland. The therapist must create space in the session - alongside the defensive rituals - for an authentic, dyadic relationship [10-12].

It is reasonable to expect that as the child comes to recognize and make use of the therapist's non-threatening external presence, they will gradually be able to play in a genuine way again. The child will regain access, even if partially, to both the internal "inside" and the external "outside" (the therapist), restoring the play between them.

Case Illustration; "Yossi" (pseudonym) Yossi, almost five years old, had been exposed for years to a very difficult external reality. He was the son of a highly problematic mother and of a father largely absent from his upbringing. Yossi's mother treated him in a feminizing way—reportedly dressing him as a girl at his request and providing a pseudo-feminist rationalization. To survive his relationship with his mother, Yossi identified completely with her wishes: he spoke in the feminine form, played with dolls, and dressed as a girl. Referral to treatment followed severe speech impoverishment, behavioral disturbances, and provocative sexualized conduct toward peers.

In the first therapeutic session Yossi appeared entirely engrossed in rich dramatic play. Over time, however, it became evident that this was not play but a repetitive ritual with no change and no engagement with the therapist. The ritual consisted of immediately going to the Barbie dolls and costume cabinet, undressing and redressing dolls, and repeatedly putting on and removing feminine clothing himself. No narrative developed, and there was no dialogue between characters. When the therapist attempted to introduce meaning into the ritual, Yossi either ignored or retreated. This pattern consumed the entire session and showed no evolution.

At a certain point the therapist implemented the approach proposed here: she insisted on interaction with Yossi and limited the time allotted to the repetitive costume/doll ritual. Initially Yossi strongly resisted. Later he acquiesced and, during the residual time between the ritual and the session's end, initiated a game of hide-and-seek with the therapist in the room. Yossi showed marked excitement when the therapist found him, as if to say, "It is effortful to find and encounter me where I truly am, not where I am placed by others, and I must be found there".

In that session a first seed was sown in Yossi's world: a non-threatening relational encounter with an external other. It will likely take more time before this relation becomes mutual and yields joint dramatic play. Nevertheless, Yossi's play mechanism had begun to function again, supplanting the prior stuck ritualistic regressions.

3.2. Treatment when the Internal Imaginary Domain is Silenced

'Hyper-Realities' I refer to this condition as one of "excessive reality" or "hyper-realities." Here the therapeutic aim is to restore the internal imaginative domain. The child is typically unable to engage directly with fantasies concerning traumatic life events; therefore, alongside the concrete coping strategies to which the child clings, the therapist must deliberately create space for a manageable imaginary realm. That imaginary domain must not be emotionally overwhelming - otherwise the child will experience it as dangerous. It should be constructed so that it does not closely resemble the child's current life experiences and thus will be tolerable and playable. Once an inside–outside territory is reestablished, the full play range necessary for healthy development becomes available again.

Case Illustration: "Karmit" (pseudonym) Karmit, nine years old, had been exposed for years to a difficult life reality (her mother suffered from a malignant illness). The family attempted to maintain normal routines while avoiding explicit discussion of the illness; nevertheless, fears and anxieties remained beneath the surface. Karmit was referred for therapy because of concentration problems at school and undefined fears.

Early in therapy Karmit repeatedly explored the dollhouse, disassembling its contents - figures and furniture - examining each element carefully, counting items, and returning them to perfect order. She never reached authentic play. The therapist's attempts to speak about the importance of neatness or to co-construct a story that might touch Karmit's distress met with resistance and anger: "It's just a plastic house, can't you see?" Karmit refused to speak - directly or indirectly - about the events of her life, and her ordering of the dollhouse consumed the session without generating a meaningful connection between therapist and child.

At a certain point the therapist intervened actively to unfreeze the therapeutic process. She limited the time allocated to the ritualized disassembling/reassembling and introduced new materials, including pink modeling clay - chosen deliberately for its cheerful hue - and a medium favorable to shaping by hand. Karmit was initially hesitant but soon accepted the invitation and, for the first time, asked the therapist to help sculpt a family of figures with furniture and varied foods. After completing the sculptures, Karmit unexpectedly engaged in symbolic play with the therapist using the figures. The world they enacted was completely different from Karmit's lived reality: she dramatized a pink child with a pink birthday full of pleasures and gifts - although one gift turned out to be a slight disappointment. The play allowed Karmit to touch briefly on painful emotional repertoire related to disappointment. This engagement was possible precisely because it occurred within the protected "pink territory" of the invented birthday.

4. Conclusion

This paper described two patterns of absent play capacity in children and outlined an intervention to restore this essential function - a phase that can be termed "pre-psychotherapy". Only the restoration of play opens the way for subsequent therapeutic work involving in-depth processing of painful and conflictual emotional content. Play capacity serves to mediate between two worlds - the external reality and its harsh or intolerable demands, and the threatening, unsettling imaginary world. By enabling a dialogue between these worlds, play supports adaptation and coping and is therefore vital for continued healthy development and effective coping capacities.

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