
Interactive Resonance in Work with Children and Adolescents: A theory-based concept of interpersonal relationship through play and the use of toys

Interaktionsresonanz in der Arbeit mit Kindern und Jugendlichen – Ein Theoriebegründetes Konzept der interpersonellen Beziehung über Spiel und Spielzeug

La Resonancia Interactiva en el trabajo con niños y adolescentes: un concepto teórico de relación interpersonal a través del juego y el uso de juguetes

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Abstract. Play therapists give evidence of Interactive Resonance by playing with the child and by responding to the child's play through their own playing activities on a bodily level, by verbal or nonverbal means. This enhances their capacity to be primarily supportive and encouraging and to give the child space, thus increasing the child's symbolizations on a deeper level. This concept is supported by developmental psychological theories: Stern's theory of self and the theory of attachment behavior enrich the client-centered theory of personality and of empathic interventions. They indicate how empathy and authenticity can be offered in play interactions with a child or an adolescent. Brief descriptions of how in practice the therapist reacts to the child's actions present examples of how to proceed in games with rules, role playing, fights, and setting boundaries.

Zusammenfassung. Spieltherapeuten zeigen Interaktionsresonanz, indem sie zusammen mit dem Kind spielen und auf das Spielverhalten durch eigene Spielhandlungen antworten, körperlich, verbal und nonverbal. Dies erweitert ein hauptsächlich unterstützendes, ermutigendes und Raum gebendes Verhalten durch Ermöglichen von zusätzlichen und tieferen Symbolisierungen. Entwicklungspsychologische Theorien stützen dieses Konzept. Die Selbsttheorie von D. Stern und die Bindungstheorie bereichern die klientenzentrierte Persönlichkeitstheorie und die Theorie empathischer Interventionen. Sie geben Hinweise, wie Empathie und Authentizität in Spiel-Interaktionen mit einem Kind oder Jugendlichen gezeigt werden

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können. Beispiele und kurze Beschreibungen, wie in der Praxis ein Therapeut auf die Handlungen des Kindes reagiert, zeigen das Vorgehen in Regelspielen, Rollenspielen, beim Kämpfen und Grenzen Setzen.

Resumen. Los terapeutas lúdicos dan una evidencia de Resonancia Interactiva jugando con niños y respondiendo al juego del niño a través de sus propias actividades de juego en un nivel corporal, por medios verbales y no verbales. Esto desarrolla la capacidad que tienen para, ante todo, ser fuentes de apoyo y aliento y para darle al niño espacio, y así incrementar la simbolización del niño en un nivel más profundo. Este concepto es apoyado por teorías de desarrollo psicológico: la teoría del self de Stern y la teoría del comportamiento de apego enriquecen a la teoría centrada en el cliente de la personalidad y de intervenciones empáticas. Esas teorías indican cómo la empatía y la autenticidad pueden ser ofrecidas en interacciones lúdicas con un niño o un adolescente. Descripciones breves de cómo el terapeuta reacciona en la práctica a las acciones del niño presentan ejemplos de cómo proceder en juegos con reglas, role-playing, luchas y establecimientos de límites.

Keywords play therapy, therapy with children and adolescents, client-centered psychotherapy, special education, self psychology, interpersonal interaction, attachment behavior, nonverbal communication.

In the twentieth century, no one supported the idea that the relationship between the therapist and the client is decisive for effective psychotherapy as early and in such a differentiated way as Rogers and the theory of the client-centered concept as a whole (Rogers 1951, 1959; Axline, 1947). The incongruence between self-concept and organismic experiencing is reduced within a therapeutic relationship based on the three client-centered core conditions. Through and within an accepting relationship the client can become aware of his or her subliminal organismic experiencing and integrate it into his or her revised self-concept. However, this basic idea of the client-centered therapy process only partly explains the significance of the conditions of a client-centered relationship. The therapist also involves him- or herself on a personal level and in an authentic way while focusing on the here and now within the relationship. This is also what Rogers meant when he spoke of authenticity. He implemented it in his therapeutic work, but he did not at first describe and elaborate it explicitly. This happened, however, when in the 1950s and 1960s client-centered empirical and experimental psychotherapy research was undertaken. At a time when Ruth Cohn, for example, still had to fight for the counter-transference of the psychoanalyst not to be seen as an incompetence and as disturbing (Cohn, 1959), here scholars were experimenting with constructs such as therapist self-disclosure, immediacy within the relationship and confrontation (Carkhuff, 1969; Swildens, 1991; Pfeiffer, 1991; Kessel and Linden, 1993; Finke, 1994).

In this paper, I first provide a brief overview of the main concepts of person-centered play therapy, highlighting the need for a more interactional approach to theory and practice. Next, I introduce the key concept of *interactive resonance*, an extension of the concepts of acceptance and empathy into the nonverbal realm. Drawing on the work of Daniel Stern and the attachment theorists, I describe how this principle is particularly relevant to work with children and elaborate its application to several important situations in play therapy, including games with rules, role playing, fights, and setting boundaries.

CONCEPTS OF PERSON-CENTERED PLAY THERAPY

In particular, the classical client-centered concept for child therapy developed by Virginia Axline (1947; Tausch and Tausch, 1956) is of key importance. Although her book is already more than 50 years old, everything it tells us is valid for the way we look at children today, including their need for space to unfold and the way adults should relate to them. Axline's fundamental principles, her respect for the child and its non-manipulated growth, are valid even today, with regard to the concept as well as to the ethics and the attitude of the adult person. The helping relationship that she outlines offers a lot of space for the child to develop freely. The child moves about in the playroom — he or she is free to choose and play *his or her* games. The therapist affirms, gives permission, refrains from judgmental comment by simply repeating, and in that way verbalizing the child's experience. Axline evokes the image of an accepting adult person sitting on a chair while observing very accurately what happens, a person who is present verbally and keeps a record on a notepad in the absence of electronic media. She joins in the play or gets involved more strongly herself only when the child explicitly invites her to do so. This therapy concept is based on the assumption, as described above, of a change process in which congruence increases in a person through unconditional acceptance offered by the other person. However, one client-centered therapy dimension which is missing from Axline's work is attention to the 'here and now' relationship between her and the child.

This is also clear in the concepts of Schmidtchen (1974; 1976; 1989; 1991; Schmidtchen and Baumgärtel, 1980; Baumgärtel, 1975). He deserves credit for his empirical research through which, in accordance with client-centered tradition, child therapy has become part of the very small circle of psychotherapeutic methods that are grounded on serious psychotherapy research. Schmidtchen and his co-workers achieved multifaceted and very helpful differentiations and operationalizations of therapist- and client variables and demonstrated differential methodological approaches. However, once again there is little attention to the 'here and now' of the therapeutic relationship. Like Axline, Schmidtchen sees the therapist as only very reservedly playing along, approximately 30 per cent of the time (1989, p. 126–133; 1991, p. 114).

In contrast, Moustakas (1953; 1955; 1959; 1997) and Landreth (1991) emphasize the central significance of the relationship. However, in his many examples of play therapy Moustakas gives only transcripts of dialogues. His plea for strengthening the child's personal power seems to be equally as determined and touching as Axline's, but there is no explication of how the therapist interacts with the child, either through play or other behavior. In contrast, Landreth differentiates Axline's principles in a more concrete way while working strictly from a relational therapy paradigm. His approach comes with a mature concept of a person-centered filial therapy that proved its efficacy in several outcome studies and with several populations.

Current textbooks that summarize person-centered psychotherapy for children are Wilson, Kendrick and Ryan (1992), West (1996), Norton and Norton (1997), Landreth (2001), Weinberger (2001) and Goetze (2002).

INTERACTION AND RELATIONSHIP IN PLAY THERAPY: INTERACTIVE RESONANCE

Using this earlier work as a basis, this paper proposes to extend the current concepts for person-centered interaction in play therapy by focusing on the immediacy of the relationship between child and adult. How can adults respond to the child's actions not only verbally, but also by play actions of their own? If the therapist explicitly and implicitly offers to play with the child, thus establishing immediate contact, this will reduce the incongruence in such areas of self-experience where language as the only medium offers few adequate possibilities for symbolization. The principle of non-directed self-development can be extended and applied in such a way that it will govern the immediate interaction, the negotiations and the way child and therapist play together. To illustrate this, individual therapeutic interventions will be described here in detail. Using constructs such as empathy, authenticity, affect attunement, responsiveness, mirroring, reflection, asocial reaction or reinforcement to describe these interventions would not be entirely misplaced, but neither would it be altogether satisfactory.

In the play sessions the child reproduces relationship patterns. For this he or she uses different play media that go beyond language. In the interaction the therapist uses the media the child chooses, thus offering verbal or nonverbal *resonance* by his or her own way of acting. While doing this the therapist is empathic on the verbal level, is responsive, tunes in with the child's affects and at times mirrors what the child is doing, although not too *literally*. Both on the level of creativity and of activity the therapist will try not to go ahead of the child, as that would be directive. But the therapist will also not remain too far behind the child, as that might become boring and would reduce the therapist's immediacy and presence.

For this form of relational engagement I suggest the term 'Interactive Resonance'. Such a new construct seems to be useful here, because already existing constructs like responsiveness, affect attunement, mirroring, etc. name only partial aspects of play therapeutic interventions. Interactive Resonance can offer a more comprehensive and holistic description. Primarily it represents an enhancement and a modification of the client-centered core condition *empathy*. Interactive Resonance, however, also has a lot to do with the *authenticity* of the therapist. In reaction to what the child does, the therapist acts and focuses on the relationship by showing him- or herself as a person who is present and who gets personally involved in the relationship.

The following example demonstrates how the therapist accomplishes a shift in the therapy by switching from an orthodox clarifying and supportive behavior to Interactive Resonance:

Example 1: Karen wants to build a tower by piling up the chairs in the play room, putting them on the table and then sitting on top of them. The therapist starts to do the same and competes with her in building the highest tower.

Brief comment. Not only boys repeatedly build towers. In early sessions the therapist helped Karen in the same game by verbalizing her emotions, motivations and cognitions, as suggested by the orthodox concept of non-directive play therapy. For Karen this was stabilizing and clarifying. When she performed this game in the previous session and the therapist only assisted, it was rather boring for both of them. Now it is about the relationship, about

competition, about who is the boss. Now the therapist with his Interactive Resonance has entirely grasped the inner issue of the child as a relationship issue. At the end of the session, both are sitting on their chair towers and discussing whose is the bigger and has more to say. Being confronted with the therapist's different behavior, Karen could experience herself dealing with issues like competition and power. It is likely that symbolization took place and that it was deep and persistent, as she experienced it in a real relational situation.

GAMES WITH RULES

How can the therapist respond when the child or adolescent chooses a game with rules? The examples in this section show how Interactive Resonance can prevent the adult from taking a moral position (by demanding that the rules be respected) or an inferior position (by simply verbalizing the child's emotions or motivations).

When in a play session the child chooses a game with rules, perhaps a board game, a series of typical interactions with the therapist will follow: pick a game, set it up, decide who will start, move according to the rules, break the rules, express feelings after victory or defeat. Rules are the most central area of interaction here. At some point (for exceptions see below) the child will break the rules. He or she either does this without being caught or formulates new rules at the top of their voice, depending on the situation and usually to their own advantage. Educators usually react by demanding that the rules are to be respected. Axline-oriented therapists may be more permissive. They might verbalize the emotional and reflective processes that might occur in the child — and this is not necessarily a mistake. However, there are greater interactive possibilities. Interactive Resonance here means noticing what the child does and reacting not by mirroring, but by acting in a similar way.

Example 2: Sven throws four and moves five places. Now, the therapist could do the same without any comment — throw three and move four places. This could then lead to a discussion. But the therapist could also say immediately after the rule was broken: 'Ah, a new rule? Fine: We shall always move one place further than the number we throw?'

Example 3: In a dicey situation Lisa changes the rule. She says: 'One can never take the queen.' Therapeutic options: 'All right, the towers can move like the queen'; or 'All right, everybody can change the rule when it is their turn.'

What the child does evokes resonance in the therapist on the *level of action*. The child acts interactively, i.e., he or she is focused on the therapist as a person and senses him or her in their entire being as an acting person. The resonances the therapist gets are immediately focused on the relationship. There is a process of fair negotiation. The board game can become a highly interactive event in which the process is developed and clarified. In the beginning the child may be irritated or happy about the liveliness of what is happening, or be angry, not wanting to continue the game. However, the child and the therapist are in relationship, and that can be played out. On the other hand, if the therapist has to remind the child continuously that the rules are to be respected, he or she is put in the role of an educator having to represent norms and values. This can be useful on the level of education,

but not on a therapeutic level.

In all this, Interactive Resonance takes place on the basis of:

- *acceptance*. Here this means that I do not only accept the child as a person with his or her feelings, I also accept his playing activities. I welcome changes of rules and accept them in an affirming way. I might enjoy the child's creativity and I do not introduce undertones that sound rebuking, patronizing or offended.
- *authenticity*. Here this means that I am present as a person who participates in the game and who has the same rights. I do not let anyone get the upper hand over me, I look after my interests and I do not pretend to be more stupid than my other playmates. By giving Interactive Resonance, we aim to provide a deep relational experience of a new quality, thus facilitating symbolization as well as a different self-experience.

INFLUENCES DRAWN FROM DEVELOPMENTAL PSYCHOLOGY

The construct of Interactive Resonance is supported and clarified by approaches which directly draw from developmental psychology.

Changing cognitive styles: developmental therapy

Ivey's concept of developmental therapy (Ivey, 1986; Ivey and Gonçalves, 1988) is in agreement with Rogerian principles in so far as it adopts a constructivist position. It considers the client's cognitions and their cognitive style to be the reference around which therapeutic interaction is centered and personal meanings are developed. Interestingly, this therapeutic concept can be linked to Piagetian theory. But at the same time, Ivey considers his approach to be mainly a cognitive orientation using nothing but talking, arguing and questioning, even when working with young children (Ivey and Bradford-Ivey, 1990). It aims at changing cognitive styles, and not at facilitating self-experience with regard to a significant other. It complements the orthodox approach to client-centered play therapy.

More strikingly, it is Stern's developmental psychological theory that confirms the client-centered theory of self in an impressive way, while also enhancing it qualitatively. And, as will be shown, this has consequences even for the smallest details of child therapy methodology.

Views of the self — from Rogers to Stern

The development of the self takes place as 'a portion of the individual's experience becomes differentiated and symbolized in an awareness of being, awareness of functioning' (Rogers, 1959, p. 223). This awareness 'becomes elaborated, through interaction with the environment, particularly the environment composed of significant others . . . — into a concept of self' (p. 223). The awareness of being and functioning for Rogers seems to be a component of the self concept, and this awareness is developed through interpersonal experiences.

So, Rogerian theory definitely offers an interactive concept of self. Four decades later,

Stern developed a model that is similarly based on an interactive view of the self. There seems, however, to be one particular detail in which Stern's model appears to go one step further. Stern (1985; 1986) thinks that the components or basic elements of the self are not developed *through* interpersonal experiences, but *as* interpersonal experiences. For Stern the self *is* a collection of interaction experiences.

The implication of this important theoretical modification for the process of client-centered therapy could be to reinforce the new directions in client-centered practice which highlight the significance of the immediate presence of the therapist and of the immediate relationship being offered (Carkhuff, 1969; Auw, 1991; Swildens, 1991; Pfeiffer, 1991; van Kessel and van der Linden, 1993; Finke, 1994; O'Leary, 1999; Mearns, 2003). We know from Rogers' well-documented therapies that he himself used the immediacy of his therapeutic presence (Farber, Brink and Raskin, 1996). He facilitated powerful experiences of a new quality of interpersonal relationship in his work with clients before he elaborated a detailed concept of this form of authentic behavior.

Now, if Stern conceptualizes the self *as* interpersonal experience, then this implies for therapeutic practice that we should focus very strongly on the here-and-now relationship. The background of this, however, is that Stern and others doing experimental infant research want to overthrow the symbiosis paradigm developed by the group around Mahler (Mahler et al., 1975; Mahler and Furur, 1968) and correspondingly also the paradigm of narcissism theory. The results of infant research culminate in Stern's interaction theory of self: the infant as a being which from birth onwards is capable of interaction and which does not at any moment imagine that he or she is in a symbiosis with the parent, but on the contrary is always able to differentiate between self and other. In the relationship with *the other*, he or she experiences the self in a mutual process of interaction with elements of both control and submission. In order to define the basic elements of such experiences of the self that in their core are interpersonal experiences, Stern (1986) developed the construct 'RIG': Representations of Interactions that have been Generalized.

Simply put, these experiences — which are experiences of being together, for example, with the parent — are always the sum of similar small interaction episodes. They happen again and again, following the same pattern with slight variations. They are more or less mini-scripts. The interactions are generalized and stay in the infant's memory as if they were added up. They become generalized representations of interaction. They represent the self not as a state of being, but as a process: a self which experiences itself as being in a process of interaction and which then develops patterns, generalizations, invariances, etc.: the so-called RIGs.

So, our being, our self-experience, consists of relationship experiences. Why are people different? Because from birth onwards, in addition to constitutional differences, they have different relationship experiences. The nature of the individual RIGs depends on the nature of the interaction experiences, particularly the way the parent attunes his or her interaction behavior to the arousal level and the affects of the infant. For this behavior Stern uses the term 'affect attunement' (Stern, 1985). It is this affect attunement which leads to the development of RIGs and therefore of the self. The parent can adequately tune in with the

infant in specific ways within the child's range of tolerance. However, she can also understimulate or overstimulate the child, tune in with him or her inadequately or selectively, but also in an authentic or inauthentic way. Stern differentiates this in detail and according to the different stages of development of the self.

It is evident that this concept is very close to the client-centered concept of empathy and to Rogers' ideas about the development of the self. But the power of Stern's concept lies not only in the empirically based and detailed model of the development of the infant's self. This model also gives rise to ideas and concepts about optimizing interpersonal behavior with infants and children. As for the relationship with adults, this has already been developed within the person-centered framework, but Stern's model provides an additional basis for transferring these ideas to person-centered play therapy.

Two examples illustrate Interactive Resonance being stimulated by Stern's concept of affect attunement:

Example 4: While playing a board game the child might move the pieces either very cautiously or hesitantly, or also in an aggressive way. When putting out the pieces the child, for example, might snap them out aggressively or take them out with his or her fingertips in a superior, distanced and condescending manner. It is more valuable than words if I offer resonance to such behavioral dynamics on the level of action while introducing variations, i.e., by incorporating the emotional dynamics into my own playing activities in a slightly different way.

Example 5: When selecting a toy, the therapist also can resonate to the behavioral dynamics, to the emotions inherent in the child's activities. In his first play session Lars is looking at the toys on the shelves in a very timid and cautious manner. Now the therapist can quietly respond to his interest in certain games by showing interest also, by investigating them as well, but in an equally cautious way, while only slightly and only for a very brief moment *getting ahead of the child*. The therapist can also look at toys on another part of the shelf in an equally hesitant way.

The child senses that his or her play activities evoke resonance. This resonance promotes his or her self-development more than verbal acknowledgement and acceptance: the therapist acknowledges and allows what the child does by means of his or her own way of acting by picking up the child's activities and by not imposing anything on him or her, thus *not getting ahead of the child*.

From attachment theory and infant research to the behavior of the important other

Another theoretical model, with similar fundamental thoughts, is provided by attachment theory (Bowlby, 1969; 1973; 1980; Ainsworth et al., 1978). Attachment theory research extensively deals with the question of the way in which attachment experiences, present from the moment of birth, define the person's way of being, sometimes throughout a lifetime, as interaction patterns, experiences of self, even as assessments of social, emotional and cognitive competence (Ainsworth et al., 1974; Ainsworth and Bell, 1974; Grossmann et al., 1988; Grossmann, 1989; Grossmann et al., 1991; Suess, Grossmann, and Sroufe, 1992). Therefore, attachment research has become extraordinarily significant for therapeutic practice (Höger,

1996). This research demonstrates how clients' patterns of attachment correlate with coping strategies (Schmidt, Höger and Strauss, 1999), outcome experience (Höger and Wissemann, 1999) and interpersonal relations issues (Höger, 1995).

Of special interest to us are models of how different attachment experiences are made. According to Ainsworth, this stems from the different attachment behavior parents display. In order to be able to describe this attachment behavior accurately, Ainsworth et al. developed the construct of maternal *responsiveness*, which is quite similar to *empathy* in client-centered theory and *affect attunement* in infant research (Ainsworth et al., 1974; Grossmann 1977). For this she developed a scale of nine levels, with accurate behavior-oriented descriptions similar to the client-centered scales for therapist variables.

Apart from corresponding with the client-centered concept of *empathy*, the concepts of *affect attunement* and *responsiveness* also include nonverbal actions such as eye contact, facial expressions, onomatopoeia, play behavior, etc. The construct 'Interactive Resonance' includes these elements as well, and in addition it implies that the therapist's behavior provides the opportunity for the child to experience a relationship with an authentic, self-disclosing and immediately present person. The therapist is present as a real person who gives behavioral responses to the actions of the child or adolescent on a real level. Some elucidating examples for this can be drawn from situations where role play, fighting and setting boundaries are required.

ROLE PLAYING, FIGHTING AND SETTING BOUNDARIES

Fights may come up very quickly in any playing activity, particularly in the turbulent mid-phase of a therapy process where the self-image is often revised and restructured.

Example 6: Maria wants to let the toy cars race between her and the therapist. She pushes the cars in the direction of the therapist in an increasingly aggressive way and he sends them back in an equal manner. There are several car crashes, and at some point there is a crash between two cars that Maria and the therapist are holding in their hands. They start to try to push the other person away, like two arm-wrestlers. The therapist regulates his pressure according to Maria's pressure, sometimes more, sometimes less, a lively fight going back and forward.

Giving Interactive Resonance in fight situations concretely implies that the energy that is directed towards the therapist is returned with a similar dynamic and intensity. The therapist should offer a kind of *dynamic resistance*. This resistance is not strong or hard, inflexible like a wall, but rather consists in drawing back, reapproaching, again and again allowing new possibilities of interaction, like a common dance where at first both are leading alternately.

For Interactive Resonance in fighting we need to be aware of restrictions: in spite of the dynamics, the therapist should try to stay sufficiently aware of him- or herself in order to notice in time when their boundaries are threatened. The therapist should not allow this to happen and should immediately insist on respecting the existing rules or not accept this kind of fighting.

Example 7: Arnie wants to box with the therapist. The therapist insists that no boxing is allowed 'on the head and below the belt' and he reacts when these rules are even slightly infringed. He insists that the rules are respected and even interrupts the fight. Of course it is also possible that the therapist does not want to box against Arnie at all. In that case he should not do so.

Example 8: In a role play Kai wants to lock himself up in the big cupboard and then also lock up the therapist in there. This goes beyond the therapist's boundaries and he does not allow this to happen.

Quite often in the course of role playing, a conflict with the therapist on the level of the real relationship occurs. At some time in the playing there is a point where the child asks the therapist to do something that is impossible, that would infringe the rules applying within the playroom, or that goes beyond the therapist's personal boundaries. Usually this is a therapeutically valuable moment, because here, similarly to what was described for the other play categories, it is necessary to negotiate about one's interests in an authentic interaction. The conflict is fought through, and the relationship is clarified.

Example 9: Mirco stages sadomasochistic rituals in the mid-part of the therapy process. For example, putting one's hand on the hotplate of the toy stove and the other person turns it on. Now he wants to do that on the real stove in the small kitchen. The therapist refuses and verbalizes her feelings about that and about him: she does not want to be tortured really and not torture him really, it hurts her and she does not enjoy it, etc.

A therapist who is involved in such conflicts or fights almost to the edge of his or her personal boundaries would not be able to do therapy anymore. Also the relationship would be out of balance. It is essential that he or she takes care of his or her own boundaries, and that thus he or she remains able to maintain the relationship and the ability to act. This can be very different depending on the age, the gender or the mentality of the therapist. It would be problematic only if the therapist had grave difficulty in maintaining a conversation with the child or was unable, for his or her own part, to handle verbal conflicts.

DISCUSSION

Differential incongruence, interactive resonance and a deeper level of symbolization

Apart from his systematic efforts to conceptualize incongruence in a detailed and coherent way (cf. Speierer, 1994; Finke and Teusch, 1991; Teusch and Finke, 1993), Stern's concepts (1985; 1986) offer a developmental psychology perspective. He developed his interactive paradigm of the self by differentiating among several areas in the infant's other- and self-experience. In the interaction with the important other, the infant experiences different aspects of him- or herself depending on his or her age. In these areas of the infant's self-experience, interactions with important others inevitably take place in a context of imperfect empathy and responsiveness and with partially flawed affect attunement, mirroring and resonance. This leads to the development of incongruence between the self-concept and the

organismic experience, and Stern's model enables us to differentiate between different areas of self-experience. How a subliminal organismic experience can then be symbolized in the self-concept equally depends on the area of self-experience in which the incongruence was developed; but also to what extent effective vs. inadequate verbalization has played its part and how far an appropriate language has been developed.

In the area of *language*, the symbolizing process for client-centered therapy and for every therapy that is based on words seems very clear: in the process of symbolization we find a verbal description for subliminal organismic experience. Already, at an early stage, the important other agrees with the child upon the meaning of terms, like for example *lively*, *sad*, *funny*. These terms do not correspond one-to-one with the child's pre-verbal organismic experiences. The strength and the most satisfying part of person-centered therapy processes is the uncovering of meanings and the adequate reframing of organismic experiences. For this to occur, therapist and client must often use metaphors or involve themselves in pre-verbal processes by seeking terms that express as closely as possible experiences for which it is hard to find the precise words. Often adult clients are also able to symbolize an attitude, an action, an image or a piece of music using nonverbal means.

However, incongruence can also be based on interaction experiences that are initially far removed from the possibility of verbal symbolization, for example when a person in his or her interactivity has had little experience of owning their self-experience. This, according to Stern, is a lived segment of the core self. Such fundamental incongruences also have the effect that clients, through their behavior, reproduce with their therapists relationship experiences that belong to their interactions with significant others.

Therapists, and in particular those who work with children and adolescents, know that these phenomena usually require two things. On the one hand, they need to be addressed so that they can be processed on a verbal level through cognitive reflection and so that the meanings can be renegotiated. On the other hand, they also require that the therapist always *behave* authentically while empathically tuning in to the reproduced relationship experiences. The therapist responds by his or her way of acting. When such processes are successful, the client is able to develop symbolizations of more fundamental significance, and in therapy this usually marks an important step. The client is able to have a relationship experience in therapy. Stern would say that a RIG (perhaps even a cluster of RIGs) is actualized, put into a new context and, after having been modified, is integrated into a revised self-gestalt.

The potential of differential and adequate therapist behavior

In considering the implications for practice, it may be particularly important to emphasize once more that the principle of Interactive Resonance is useful only when it is implemented in such a way that the child is able to symbolize experiences that are insufficiently integrated into the self-concept. Many phases of therapy with children or adolescents require that the therapist behave in a nurturing, empathic, non-confronting and space-giving way. In the beginning of therapy, *Sven* may be so fragile and have so little self-esteem that he simply cannot bear to lose a board game. The therapist should thus find a way to accept rule violations

for quite some time before offering Interactive Resonance, which can appropriately come later. When *Mary* is cooking a meal for the adults using dirt, snakes, flies and excrement, the question is whether the therapist should eat this meal (in fantasy) on demand. Perhaps in the initial phase of a therapy he or she should do so, but should refrain from doing so when offering Interactive Resonance at a later point.

While working with severely disturbed children and adolescents, i.e., in cases where the self-structure is fragile, it is better not to get involved in competition and fights in an immediate and dynamic way. Clients who in their social environment often feel quickly threatened, and who then display aggressive behavior without any transition, will react to any irritation in an extremely escalating way. Here we cannot be sure that Interactive Resonance will result in symbolization of subliminal organismic experiences of aggression. The client rather experiences him- or herself as threatened and believes that he or she can defend him- or herself only by means of aggression. In general, the same goes for children who feel overwhelmed by their emotions.

The construct of Interactive Resonance offers a theory-based method in order to enrich therapeutic procedures that are grounded on a relationship paradigm. It enhances the possibilities for symbolization emerging from interactive experiences. It carries forward the client's issues and problems that seem to be stuck in repeatedly staged scenarios. It enriches a therapeutic relationship based on nurturing, space giving and supportive behavior. This is the formulation for every therapeutic process — and Interactive Resonance can add interpersonal experiences of relatedness, of attunement, of cooperation and of competition that add immeasurably to the dynamic potential of the relationship. When this is possible, therapist and client entered an altogether richer terrain.

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