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Child Centered Play Therapy with Traumatized Children: Review and Clinical Applications

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Keywords: Child-centered play therapy, traumatized children, counseling, skills,
Abstract

The purpose of this manuscript is to identify the necessary components for play therapy with children who have experienced trauma. An examination of the role of the play therapist from a child-centered perspective is discussed. Origins for play therapy as well as child-centered play were conceptualized for practical application. Clinical considerations and future directions for this type of therapy were also presented.
Play Therapy with Traumatized Children: Clinical Applications

Trauma can happen to any individual at anytime throughout the course of their life. For children and adolescents, traumatic events can affect their lives significantly in various ways (Dripchak, 2007). It is important to remember that children are people, but they are not miniature adults; subsequently, they have an inherent tendency toward emotional growth and have the capability for positive self-direction. Furthermore, children can demonstrate their ability to or not to speak, and will take the therapeutic experience where they need to be (Landreth, 2002). It is important for children in therapy to have flexibility with their language and the choice to verbalize their feelings using words or toys.

Children experience and internalize traumatic events in various ways. The ability to express their feelings and emotions is contingent upon a safe, therapeutic relationship with a qualified therapist. Drewes (1999) indicates that children who experience trauma should be treated by trained professionals that incorporate specialized techniques that address the effects and behaviors associated with this experience. James (1989) found that trauma can impact children on several different levels. These levels include their intellectual, social, and psychological development; thus, influencing the child’s self esteem and pattern of behavior.

Play Therapy

Play is a child’s natural means of communication, exploration, and thinking, just as talking is an adult’s way of doing these things (Landreth, 2002). Play therapy is to children what verbal communication is to adults. Children possess the ability to find their own meaning and potential through the play therapy process. In the playroom, toys are
utilized, used like words: play is the child’s language and mode of communication with the therapist. Play therapy has numerous benefits and advantages for which empirical studies echo the efficacy for its use and application with children. Various clinical issues that play therapy has been effectual include working with children suffering from attachment disorders (Ryan, 2004), post traumatic stress disorder (Ogawa, 2004; Ryan & Needham, 2001), autism (Josefi & Ryan, 2004), and grief (Thornburg, 2002). There are also a number of additional empirical studies that are specific to children dealing with traumatic events such as physical or sexual child abuse (Hill, 2006; Mullen, 2002; Scott, Burlingame, Starling, Porter, & Lilly, 2003), witnesses of domestic violence (Frick-Helms, 1997), and homelessness (Baggerly, 2004). These areas of research have been instrumental in understanding the prevalence and significance of traumatic events upon children.

Glazer (1998) studied the use of play therapy when working with the expression of grief with children. Nine children participated in expressive arts activities and through this process their drawings seemed to show a greater integration of their grief experiences. It was concluded that through this study, the Rosebush technique (Oaklander, 1988) can be helpful in understanding the grief process of children. In a study conducted by Homeyer and Landreth (1998), authors found strong positive intercorrelations between play therapy behaviors and those of children who have been sexually abused. The process for identifying this type of trauma can be very difficult; whereas, personal disclosure should be processed in a therapeutic setting.

Ryan and Needham (2001) conducted a case study with a nine-year-old child who had developed stress reactions to a traumatic event, in which they labeled post traumatic
The authors discussed themes in the child’s therapy, as well as the role of the therapist and the parents. They found that children with PTSD may be able to work through their issues through the use of non-directive play therapy.

Jones and Landreth (2002) investigated the effectiveness of play therapy for chronically ill children diagnosed with diabetes, specifically insulin-dependent diabetes mellitus (IDDM). Their study was used to determine if play therapy was (a) effective in reducing symptoms of anxiety with these children, (b) reducing overall behavior difficulties, (c) increasing healthy adjustment, (d) increasing adherence to their diabetic regime, and (e) having an impact on these emotional and behavior symptoms over time. The authors found that play therapy significantly improved the children’s adaptation and coping strategies with the medical diagnosis of diabetes. The results indicated that play therapy is an effective therapeutic modality of treatment for children with IDDM.

Another study by Shen (2002) demonstrated short-term group play therapy with Chinese earthquake victims on the effects of their anxiety, adjustment, and depression. The researcher found that children who participated in group play therapy scored significantly lower on the suicide risk and anxiety level than did children in the control group, who did not participate in group play therapy. The author found the results of this study support the use of child-centered group play therapy as an intervention for Chinese children possessing anxiety and suicidal ideation.

More recently, Reyes and Asbrand (2005) conducted a longitudinal study which assessed trauma symptoms with sexually abused children who were involved in play therapy. The authors found that after children participated in play therapy for six months, their trauma symptoms severity decreased. Additionally, they found that depression,
anxiety, and post-traumatic stress, and sexual distress also decreased. The aforementioned research studies demonstrate the empirical support and efficacy of play therapy and different types of trauma that can affect children in many different ways.

Clinical applications for the use of play therapy allows for trained professionals to better communicate with children to help them recover from traumatic events and achieve optimal mental health. Play therapy is a specific natural way for therapeutic communication that encourages children to work through their feelings and emotions about their world. Play therapy fosters the development of positive self-concept, while providing the child a safe and structured, therapeutic environment to become more self-directing, self-reliant, self-accepting, and in turn allow the child to experience a feeling of control (Landreth, 1993). Children learn through the process of play therapy to exhibit control and responsibility when confronting problems in everyday situations. Through the therapeutic relationship, children can understand that their feelings are real and acceptable. This is a critical juncture within the therapeutic dialogue as it will reinforce the philosophy that children are in a safe, nurturing environment tailored to their experience.

Early in the play therapy movement, Virginia Axline (1947) developed eight basic principles for play therapy. These eight principles include the therapist; a) developing a warm friendly relationship with the child, b) accepting the child exactly as they are, c) establishing a feeling of permissiveness, d) recognizing and reflecting feelings back to the child to gain insight into his/her behavior, e) deepening a respect for the child’s ability to solve his/her own problems while recognizing the responsibility for change is the child’s, f) making no attempts to direct the child, g) making no attempts to hurry the
process, h) establishing only limits that anchor the session to the world of reality, while making the child aware of his/her own responsibly. Although these principles were developed over half a century ago, they are still evident and purposeful in play therapy practices today.

Child-centered play therapy (CCPT) was Axline’s transformation of traditional client-centered theory (Rogers, 1951) which was continued and expanded upon by the work of Landreth (2002). CCPT is a therapeutic way of being with the child rather than a method of doing something for the child. The specific goals of CCPT are to establish a safe environment where a child is free to express his/her emotional world through play while facilitating decision making, a feeling of control, and to help the child verbalize his/her experience (Landreth, 1993). The therapist accepts the child unconditionally without regard to behavior or history of treatment. Through CCPT, children can use dolls, puppets, paints, or other toys in the playroom to express what they think or how they feel.

When children are able to use play to communicate how they feel to a trained play therapist, they feel better because their feelings have been accepted and validated. According to Landreth (2002), play therapists convey four healing messages to children; a) I am here, b) I hear you, c) I understand, and d) I care. The process of CCPT allows the child to lead and the therapist to follow. Play reveals to a therapist what a child has experienced, their feelings and reactions that surround the experience, and the child’s needs.

There are distinct stages that become observable through play therapy which include; a) exploratory stage, b) aggressive stage, and c) dramatic stage (Landreth, 2002). During the exploratory stage, children are non-committal; they are creative in their play
and curious about toys in the room. In the aggressive stage, children may verbalize or act out feelings about their family, self, or situation. During the dramatic stage of play, children express anxieties and fears as well as relationship play. Relationship play emphasizes the relationship in which the therapist and child develop that becomes curative in nature.

It is necessary to understand that play can be spontaneous. It is complete within itself and highly variable across situations and children. Play does not have rules or regulations, it is invented. It permits children to deal with emotional experiences and feelings through the symbolism of toys used in play therapy. Symbolic play allows children to bridge the gap between their abstract thoughts and concrete experiences (Ginott, 1975). It lets children make what is unmanageable, manageable- symbolically. Play organizes the child’s experience into an understandable form and reorients the child to the present moment. It also creates a personal world for the child where he/she continually discovers about him/her self.

There are two types of play that become evident when working with children; adjusted versus maladjusted (Landreth, 2002). When a child’s play is adjusted; it is free, spontaneous, and will use a wide variety of materials. The child will be comfortable with not only his/her play, but the therapist as well as his/her involvement in the playroom. Children can make decisions on their own; their play is self-initiated, exhibits a high sense of autonomy and is self-regulated by their own emotions and feelings. Children use play as a concrete way to disclose their problems and display expressions of their feelings. Adjusted play tends to be non-repetitive and there is evidence of less fantasy play.
When a child’s play is maladjusted (Landreth, 2002), which can also be referred to as post-trauma play, (Gil, 1998), a child will play cautiously and deliberately. The child will play with a few toys, in a small area of the playroom. There can be significant fluctuations in play therapy when children experience maladjustment. These variations in behavior may include aggressive or destructive conduct during play, displaying intense feelings, frequent play disruptions, high levels of fantasy, and conflicting themes. These types of children are highly dependent on the therapist and exhibit high anxiety throughout their play therapy experience. These children display a low sense of autonomy and decision making skills. They are apprehensive about the therapeutic relationship and limited in their conversation. These children also exhibit a highly intense expression of emotions and a limited range of those emotions. Maladjusted play tends to be repetitive and there is evidence of more fantasy play.

The key between adjusted versus maladjusted play is the intensity and quantity of the play, not necessarily the negative attitudes of children. Expressions of negative attitudes is more frequent in maladjusted than adjusted; however, that can be evident in both types of play. Disorganized and disruptive play behavior is highly representational of maladjustment yet, it is important to remember it is the intensity and quantity of this type of play which will differentiate the two. It will occur sporadically with adjusted play as well.

In contrast to objective based counseling which is goal focused and directed towards completion of a task while accommodating the demands of the immediate environment, play is intrinsically complete. It does not depend on external rewards and it assimilates the world to match the child’s concept. Play is the way children learn what no
one can teach them. It is the way they explore and orient themselves to the actual world of space and time, things, animals, structures, and people (Landreth, 1993; 2002). By engaging in the process of play, children learn to live in our symbolic world of meanings and values, and at the same time give their imaginations free rein, learn the trappings of their culture, and develop skills. Play can help children overcome defenses against anxiety, verbalize certain conscious material, act out experiences related to feeling, and relieve tension. Play also lends a hand to developing a working relationship between therapist and child.

Play therapy facilitates verbalizations and creates the necessary space for a child to work through his/her traumatic events. Through play, a child can learn to trust and respect themselves as well as how to identify and accept their feelings. Children can initiate self control, how to take responsibility for self, and learn to be creative and resourceful when confronted with problems. Through this self-direction, children discover how to accept themselves, to make choices, and to be responsible for those choices (Landreth, 1993; 2002).

Skills

Therapeutic responses in CCPT are brief and interactive which encourage the child to lead the counseling session. The therapist practicing from this theoretical base, should avoid instructing and labeling, instead reflect and track the child as they play. For example, a child may decide during play that they are going to use a pencil for an airplane. As an adult, it is only natural to want to correct the child, but by doing that, the child’s creativity is stifled. Another important component to CCPT is for the therapist not to ask questions during the session. To a child, this may imply a sense of non-
understanding or that the therapist has not heard the child. It may also move the child from an emotional realm to a cognitive one, prematurely. When therapists have sufficient information to ask a question, they have enough to make a statement, therefore the skill of reflection is more appropriate (Landreth, 2002). A child will tell the therapist if they have misinterpreted what he/she is thinking. The child will feel the session is personalized when the therapist targets responses, which in turn can be highly effective and therapeutic. Skills in CCPT are a useful and essential way to communicate with the child through the play process. Therapist skills include: a) tracking; b) reflection of content; c) reflection of feeling; d) enlarging the meaning; e) returning responsibility; f) facilitating creativity; g) encouragement; and h) limit setting (Landreth). Understanding these skills and appropriate use of them is vital for facilitating children’s play.

*Tracking.* Tracking occurs when the therapist gives a play-by-play as to what is occurring during the session. Tracking behavior can be identified as communicating the therapist’s involvement to the child and at the same time permits the child to realize that the therapist is participating. Tracking produces feelings of security and warmth that are promoted as the child hears the therapist’s voice. The therapist needs to remain verbally responsive to the children reacting in reflection of the child’s activity level. For example, if the child is playing at a high rate of speed, the verbal responses from the therapist should be at a high rate of speed, whereas if the child is sluggish in their play, the therapist would respond to the child at a slower rate of speed. The relationship deteriorates with the child if he/she feels “watched” even when the child is engrossed in play, not very talkative, or no feelings are being conveyed. The therapist should remain verbally engaged by responding to what is observed. So, even though the rate of speed is
reflective to the child’s activity level, it is still important to remain constant with therapist reflections. A therapist using the tracking skills may respond to a child’s play by saying “you’re putting that right there” or “you’re checking that out”.

*Reflection of content.* The therapist will reflect the perceived meaning or intent of the child’s actions as they observe the child’s play. This again allows the child to feel that the therapist is a participant and is present with the child throughout the process. The therapist can respond to the child’s actions when the child is not talking and should use voice inflection to convey meaning of what the child is doing. It is important not to get overly excited beyond the child’s level of excitement. Responses should be short, interactive, stay away from parroting the child, and avoid speaking in the third person. For example when a child places the bowling pins in a straight line, the therapist may respond, “It’s important to you to get those just the way you want them.”

*Reflection of feeling.* This occurs when the therapist reflects the feelings the child is expressing through his or her behaviors. As the therapist reflects the feelings that are exhibited by the child, the child will recognize these feelings and gain insight about them. Through this process, the child will clarify what they are thinking and make a positive step towards the healing process. The reflection of feeling permits the child to release feelings of deeper significance as he/she receives recognition for each feeling that he/she does express. Through this type of reflection, it conveys to the child that the therapist has understood him/her. The therapist can reflect feeling both in words, facial expressions, and body language. For example, if a child kicks over the blocks the therapist may respond “you’re angry” and make an angry face. On the opposite end if a child is singing
and smiling the therapist may respond “you’re happy” while smiling. Consistency in reflection is paramount to appropriate reflection in play therapy.

**Enlarging the meaning.** As children play, what they do behaviorally may not connect for them cognitively. The therapist will provide the child with that connection through this skill. Enlarging the meaning pulls on themes in the child’s play and helps the child organize and understand the meaning of his or her play. If a child is constantly asking for help, tries to do something, and then throws it down because of frustration, the therapist may respond, “you’re frustrated because you feel helpless.”

**Facilitating decision making and responsibility.** Children often seek advice or clarification from adults regarding what they would like for them to say or do. This can be seen when a child says things like “what should I do”, or “can I play with this?”, Instead of providing an answer to the child, in CCPT it is important to return that decision to the child by making a statement such as “you get to decide in here” or “you choose.” This skill allows the child to feel as though they have a choice in what is happening through the play sessions. CCPT therapists view children as creative, capable, resilient, and responsible beings. To make this reality, children must figure things out for themselves and trust their decisions as being appropriate. This allows the child the opportunity for projecting their own meaning onto a toy. It encourages them to take responsibly for themselves and discover their personal strengths. It also helps in the growth process, permitting them to become intrinsically motivated, strengthening their self concept, and increasing their creativity facilitates the child’s sense of control.

**Facilitating creativity.** This process communicates sensitivity, understanding, and acceptance towards a child. It also conveys freedom and responsibility. When a child is
painting, for example, the therapist will track the movements of the paint brush. A therapist may respond by encouragingly saying “around and around and around.” These types of statements help the child to know that the therapist is with them and at the same time allow the freedom to express whatever it is the child needs to express. Facilitating creativity allows the child to set their own direction as they play.

**Encouragement.** Children often look for approval from adults and peers to determine if it is good or acceptable. Praise is often given in the form of “good job” or “way to go”. This type of praise in a constant form can lead a child to believe that his/her performance is only good if accepted by others, thus leading to the child finding it a necessity to have this type of approval. Excessive praise can make a child overly dependent on this external approval. Therapists need to create an internal mechanism that fosters self esteem in children. By focusing on the child’s process, the therapist may respond to a child that holds up a piece of artwork and smiles “you’re proud of that,” allowing the child to begin work on feeling good about their own productions and not to rely on approval.

**Limit setting.** A necessary component of the CCPT process is that, it is not a free for all and boundaries do exist. Limits are set during play for several reasons. These reasons include; (a) harmful or dangerous behavior to the child or therapist, (b) behavior that disrupts the therapeutic process or routine, (c) destruction of toys or playroom, (d) taking toys from the playroom, and (e) socially unacceptable behavior. Testing limits by the child is a statement that there is a need for boundaries. The limit setting process is called the ACT model of limit setting. The ACT model follows three basic steps A = Acknowledge the feeling; let the child know that you are aware of what they are feeling
and realize that it is important to them. C = Communicate the limit; let the child know what the limit is. Be clear and concise when you are stating the limit. T = Target two choice; it is important to identify two clear choices that are both acceptable to the therapist and will match the needs of the child. Limits should be enforceable and consistent. During limit setting, it is appropriate to label the objects in the playroom. An example of limit setting encompassing the three steps might be “Janie, I know you are excited about throwing the sand, but the sand is for staying in the sandbox, so you can choose to scoop the sand in the sandbox or you could play with the sand in the bucket, which do you choose?” This gives the child a sense of control in the therapeutic situation as well as the ability to make decisions, learn self-control, flexibility, and responsibility. Limit setting not only protects the physical and emotional security of the child, it facilitates safety, predictability, and consistency for the child.

*Playroom.* The location of the playroom will depend on the type of physical setting the therapist is using. Often times, a therapist will use any room available if they are in a school for instance; however, it is ideal for the playroom to be located in an area that will not disturb others. Play therapy can be loud and verbally expressive and therefore using a secluded or soundproofed room would be ideal.

The playroom itself ideally should be approximately 12 by 15 feet (Landreth, 2002). Larger rooms make it difficult to be able to view what the child is doing through the play session. Although ideal, this size playroom is not always practical. The playroom should not have windows in the doors or on the walls, but if there are windows, shades should be drawn. Playrooms can be difficult to keep clean, so it is best to opt for a playroom with no carpet.
Toys in the playroom should be set up the same way each time a child enters the playroom (Landreth, 2002). This creates consistency for the child. The most nurturing toys should be closest to the therapist, while the most aggressive toys the furthest away from the therapist. Children should not be asked to clean the playroom before they leave the session. This allows the child not to lose the process they have experienced during the session. The therapist cleans the playroom after the child leaves the playroom. This sense of not having to do things that the child normally does outside the playroom is what allows the child to gain the sense of independence. When children are outside of the play therapy experience, they are consistently told what to do and how to behave; whereas, in the playroom they are encouraged to act freely and independently.

*Toy Selection.* Children are provided specific toys in play therapy to enable them to say with the toys what they have difficulty saying with words. Toy selection is an important component of play therapy. Housing the necessary toys to create a complete playroom is essential, but not always practical. Toys should facilitate a wide range of creative and emotional expression, engage children’s interest, and facilitate expressive and exploratory play. The toys should be of sturdy construction, allowing for expression without verbalization. Children may express their needs symbolically, and provide emotional insight for the therapist.

Toys should include real life toys (i.e. money, kitchen, cars, cash register), aggressive toys (guns, knives, soldiers), creative or emotional release toys (sand, paints, blocks, play dough), and nurturing toys (dolls, food, clothes, brush) (Landreth, 2002). It is vital to provide toys that are a representation to the trauma experienced as well, for example, be sure to include emergency vehicles and service men/women in uniforms.
When using a purist orientation, avoid using commercial labeled toys (i.e. Batman, Spiderman, Sponge Bob). The key is toy selection, not collection (Landreth).

Conclusions and Future Implications

Child-centered play therapy provides various techniques and skills that can be implemented by therapists to assist children who have experienced traumatic events. The implementation of a non-directive approach where the child can express freely without fear of judgment or punishment is paramount to the healing process. Encouragement as a key factor is fundamental to the betterment of self-esteem and the reduction of maladaptive behaviors. The playroom and the toys offer traumatized children a safe, therapeutic place to discover themselves in an affirming environment which fosters acceptance and nurturance. Finally, this unique modality can assist in creating a new world for children that promotes resiliency, boundaries, and a children’s sense of safety and adaptability.

Future directions in CCPT can be applied to various settings such as schools and clinical situations that focus on working with traumatized children. Due to high accountability for outcome measures, play therapists can provide brief sessions that can be implemented thoroughly and continue to demonstrate effectiveness. Additional experimental and correlational research studies are needed to determine support for this approach and its flexibility to be applied to specific traumatic events. Finally, research designed to correlate CCPT and academic success in schools for children can solidify the movement and validation for those who are qualified to practice this therapeutic modality.
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