SERIES EDITOR: PAULETTE M. GILLIG, MD, PhD
Professor of Psychiatry, Department of Psychiatry,
Boonshoft School of Medicine, Wright State University, Dayton, Ohio.

PLAY THERAPY

A Case-based Example of a Nondirective Approach

by TIMOTHY LAWVER, DO, AND KELLY BLANKENSHIP, DO
From the Department of Psychiatry, Boonshoft School of Medicine, Wright State University, Dayton, Ohio.

ABSTRACT

Play therapy is a treatment modality in which the therapist engages in play with the child. Its use has been documented in a variety of settings and with a variety of diagnoses. Treating within the context of play brings the therapist and the therapy to the level of the child. By way of an introduction to this approach, a case is presented of a six-year-old boy with oppositional defiant disorder. The presentation focuses on the events and interactions of a typical session with an established patient. The primary issues of the session are aggression, self worth, and self efficacy. These themes manifest themselves through the content of the child's play and narration of his actions. The therapist then reflects these back to the child while gently encouraging the child toward more positive play. Though the example is one of nondirective play therapy, a wide range of variation exists under the heading of play therapy.

INTRODUCTION

In her original work on the subject of play therapy, Virginia Axline wrote, "There is a frankness, and honesty, and a vividness in the way children state themselves in a play situation."[1] As universal as it is mysterious, imaginative play predominates the lives of most young children. More and more, we are identifying and appreciating childhood mental disorders and how they pull children away from normal functioning. This can affect their home lives, academic performances, as well as their play with peers. Play therapy offers a direct route to engage children on their terms, in their world, giving them a chance to, "play through what adults talk through."[2] The goal is to identify and address themes that arise in the course of play, although children's relative strengths and weaknesses do become apparent in terms of cognitive processing and social skills.

Studies have shown the effective use of play therapy in children with different psychiatric diagnoses. Using pre-test, post-test comparison design to evaluate 11 patients in an experimental group and 10 in the control group, Danger, et al., showed a benefit in improving both receptive and expressive language skills in children with speech difficulties.[3] In theory, the safe practice environment of the therapy provided an environment conducive to working on these areas without exacerbating self esteem and social anxiety issues. An exploratory study of nondirective play therapy with an autistic boy using video analysis of 16 sessions suggests both feasibility and effectiveness of play therapy with noted improvements in the child's autonomy and pretend play, though only mild improvement in decreasing ritualistic behaviors.[4] It was the authors' opinion in this paper that the therapeutic relationship helped to "enhance and accelerate the emotional/social development of children with severe autism," as they were able to observe attachment behavior from the child towards the therapist."

Legoff and Sherman ran a three-year retrospective study on children with autism spectrum disorders involved in LEGO therapy, a play therapy centered around the commercially available building blocks.[5] In a two-tiered approach, Robinson, et al., describe using filial play therapy to teach fifth-grade students to then be 'therapeutic change agents' in play sessions with kindergarten children identified as having adjustment difficulties.[6] Gold-Steinberg and Logan detail the use of psychodynamically oriented play therapy as an adjunct to pharmacotherapy for a child with obsessive compulsive disorder (OCD).[7] Virginia Ryan details some of the difficulties and gains in play therapy with a child in transition with serious attachment problems.[8]

In another case example, play therapy was used to alleviate anxiety, which was contributing to migraine headaches in a 10-year-old child with separation anxiety disorder.[9] In this case, the boy with preexisting migraines began to experience increased anxiety in the wake of the 9/11 attacks as his father took part in the search and rescue efforts at the World Trade Center. The tracked symptom was migraine frequency, which had increased with his anxiety. Through play and art he was able to accomplish a resolution of his fears by bringing them to the surface, directly and indirectly in the content of his play and art projects. As his play and art became less dark and fearful, both his subjective anxiety and migraines decreased.

In a related case, play therapy was used as treatment for a four-year-old boy with a psychosomatic postural symptom that resolved quickly over a course of play therapy.[10] A four-year-old boy had begun tilting his head forward and to the left subsequent to his parents learning of a left kidney defect in his as-of-yet unborn sister. He also had marked regression in speech and increasingly needy or clingy behavior. Through play the therapist was able to explore his competing themes of aggression toward his younger sister, the new holder of his parents' attention, and a fantasy-based guilt of having in some way wished his sister's malady into existence. The head tilt, along with the regressive behaviors served as

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ADDRESS CORRESPONDENCE TO: Timothy I. Lawver, DO, E-mail: timlawver@earthlink.net

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attention-seeking behavior. Also, as much of his play involved things being broken, needing to be fixed, and the idea of punishment by being hit on the head, the therapist was able to extrapolate that the symptoms also served as self punishment. By repeating these themes in the face of safe, gentle correction by the therapist, all symptoms resolved for the most part within four sessions.

Snow, et al., described two case studies followed over a six-week period.[11] One case was a three-year-old boy brought in by his grandmother for increasing aggressive behavior and violent tantrums. The other case was that of a six-year-old boy showing regressive behavior in imitation of and perhaps competition with his younger, disabled brother. The caregiver filled out the Child Behavior Checklist of Thomas M. Achenbach and Craig Edelbrock so that the authors could track the course of behavioral outcomes. The authors tracked the themes present in play from session one to session six based on a standard format. Of note was that changes in play themes in therapy were paralleled by changes in behavior at home.

Outside of the context of specific psychiatric diagnoses, play therapy has been used in a variety of other settings. Scott, et al., conducted a 10-session "client-centered" study on the use of play therapy with 26 victims of sexual abuse, ages 3 to 9. Here "client-centered" refers to a slight variation in how the play therapy session is run, although the overall format still consists of play based on themes and interests initiated by the child. However, their findings showed only mixed support for the use of play therapy in this setting.[12] A pre-test and post-test assessment battery were completed both by the patient and the primary caregiver. Many subjects showed a trend toward clinical improvement (8 of 26), but the Reliable Change Index formula failed to show a statistical difference. Baggerly advocates for the use of play therapy with homeless children to help them "gain in fantasy what [they] long for in reality."[13]

Mullen, et al., explored the use of play therapy with young people, "facing transitions as a result of relocation."[14] He presents a case study of a middle-school–age girl upset by her family's move to a more affluent neighborhood. She was able to work through the effects of this relocation and come to terms with the change through bringing the material up in the context of play therapy. In another study, play therapy was used in the preoperative period to reduce state anxiety scored in children. Li, Lopez, and Lee found a reduction in state anxiety scores and fewer negative emotions at induction of anesthesia.[15] Two hundred and three children admitted for day surgery were randomly assigned to experimental or control groups. In the experimental group, the children received therapeutic play while the control group received "routine information preparation." The authors found a reduction in state anxiety scores and fewer negative emotions at induction of anesthesia.[16]

A growing body of research supports the clinical effectiveness of play therapy for children with self-concept issues, behavioral adjustment, social skills, emotional adjustment, intelligence, and anxiety/fear.[17] In a review of 93 controlled-outcome studies published between 1953 and 2000, Bratton, et al., found an overall treatment effect of 0.80 standard deviations.[18] This effect was felt to be consistent over age, gender, and presenting issues. The largest effects were seen in therapies that involved the parents. The importance of conducting well-designed, outcome-based studies on play therapy is illustrated by another meta-analysis of published and unpublished play therapy outcome studies where poorly designed or incomplete studies were included. Rogers-Nicastro found only a between-group effect size of 0.18, indicating a lack of evidence to make any strong conclusions about play therapy.[19]

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CASE PRESENTATION: WHAT DOES PLAY THERAPY LOOK LIKE?

Rather than focusing on a particular setting or diagnosis, the following case is presented as an introductory vignette to play therapy—an example of how a typical nondirective play thereapy session might progress.

Mike is a six-year-old boy with a diagnosis of oppositional defiant disorder. His mother's behavioral concerns include noncompliance with adult requests, disrespecting attitude toward others (especially women), and explosive tantrums. Mike has been expelled from several daycares. Mike lives with his mother and grandmother. His parents divorced when he was four after a marriage marked by significant tension and disagreement. Mike witnessed their arguments, and on occasion, he saw his mother being hit and shoved by his father. Mike's father has remarried and has a newborn.

The custody agreement states that Mike's father has regular visits every other weekend and one day a week; however, he has been very inconsistent. Typically, the father misses visits or cancels at the last minute.

Mike: (Looking around the room) I don't think I feel like playing today.
Psychiatrist: You don't know if you want to do anything.

Practice point. The psychiatrist reflects back what the child has said. This intervention shows the

psychiatrist is interested and listening to the child. The psychiatrist does not attempt to engage the child in some of the games in the playroom. It is important the child lead and the psychiatrist follow.

Mike: (Continues to look around the room. He walks over to the Play-Doh bin and gets out several colors. He starts to make several cars out of the Play-Doh.) Look at my cars!
Psychiatrist: You have three cars. You made two big cars and a little one.
Mike: They're a family of cars. (He starts to pretend to drive them around the room.)
Psychiatrist: The family of cars is driving around together. They are staying very close to each other. (The psychiatrist continues to track what the child is doing, interpreting the play at times.)
Mike: (Suddenly the largest car crashes into the wall.) The daddy car was bad and hit a wall. No more daddy car! He shouldn't have done that. Now he's all gone!
Psychiatrist: That car did something bad and now he's no longer a car. (The child seems to be escalating in anger at this point. He starts to crush all the cars and turn them into balls of Play-Doh.) The family of cars is all gone now.
Mike: Yeah, now they are all bombs. I'm going to blow up this place.
Psychiatrist: The family of cars has turned into weapons. You want to blow up this building with them. (The therapist tracks his behavior and allows him to show his anger.)
Mike: I'm going to blow you up. (He starts to throw the Play-doh balls at the therapist.)
Psychiatrist: I know you would like to blow me up by throwing those bombs at me. (This comment demonstrates the psychiatrist's empathy with the child.) But you may not throw things at me. You may throw those bombs at that stuffed bear. (The psychiatrist points to a large bear sitting in the corner of the room.)

Practice Point. It is important to set limits in the play room when appropriate. The child should not be able to hurt himself, the psychiatrist, another person, or destroy property. A good way to set limits is this way: First, acknowledge what the child wants to do, e.g., "I know you would like to blow me up by throwing those bombs at me." This helps to empathize with the patient and makes it more likely the limit will be followed. Second, communicate the limit to the child, e.g., "You may not throw things at me." Third, give the child an alternative, e.g., "You may throw those bombs at that stuffed bear."[20]

Mike: (Turns to the bear and throws the Play-Doh at it.) The bear is all blown up! (He says this with a big smile.)
Psychiatrist: You are happy because the bear is blown up. (The psychiatrist appreciates his smile as being happy and reflects this feeling in her interpretation.)

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Mike: The bear is alive. (He goes over and picks up and cradles the bear.) He is hurt. I don't know if he's going to die. (Mike goes and finds the nursery bottle and starts to pretend to feed the bear.)
Psychiatrist: You are afraid he is going to die. You are going to help the bear.
Mike: He is all better now.
Psychiatrist: You have nursed the bear back to health. He is going to be just fine. (The therapist acknowledges his anger and his fear that his anger can hurt things. The psychiatrist also acknowledges his need to know that his anger will not destroy things.)
Mike: I'm going to build a house with these blocks. (Mike walks over to the bookshelf where the blocks are stored. He gets the blocks down.) You build a small house and I'm going to build a big house. (The psychiatrist does not interact in the play until invited to by the patient. The child has invited the therapist to play blocks with him. The psychiatrist complies with the child's request and starts to build a house.) Hey, your house is bigger than mine. Now, I'm going to have to make my house even bigger!
Psychiatrist: It's important to you that your house is bigger than mine.
Mike: Bigger is better.
Psychiatrist: Whoever has the bigger house is better.
Mike: Can you get those people down from the shelf? They are going to live in the house.
Psychiatrist: You can get the people down off the shelf. (The therapist acknowledges Mike's ability to do things for himself. He can satisfy some of his wants and needs.)
Mike: I think it's too high.
Psychiatrist: I think you can reach that. (The psychiatrist continues to acknowledge his abilities and encourages him.)
Mike: (Walks over to the bookcase, reaches up and grabs the play people.) I did it!
Psychiatrist: You did it by yourself. (The psychiatrist's comments reflect his abilities to do things for himself and affirm his self-sufficiency.) Five minutes until our time is over. (Mike continues to build on to his house with the blocks.)

Practice point. Giving children a five-minute warning allows them to know that you will be leaving the room

soon. It gives them a chance to finish anything they feel is important.[20]

Psychiatrist: Mike, our time together is over for today.

Mike: Just a few more minutes. I'm almost done.

Psychiatrist: I know you don't want to leave, but our time is finished. When you come next week you can finish your buildings.

Practice point. The limit of time is given to Mike. His feeling of not wanting to leave is empathized with and he is given an alternative.

DISCUSSION

The case described in this article is an example of nondirective play therapy. There are variations under the larger heading of *play therapy* that may look more or less similar to the interaction presented. For example, Trombini and Trombini detail the use of focal play therapy following Gestalt theory in children with eating and evacuation psychosomatic protest behaviors.[21] Wettig, et al., present two research projects using another style of directive play therapy trademarked as Theraplay.[22] Also, as described by Ryan, filial therapy, a variant of nondirective play therapy, can be used with children being placed with new caregivers.[23] The Masterson Approach is described by Mulherin in a case report following a mother and child for six years and relates to Masterson's conceptual framework of "abandonment depression." An in-depth discussion of these various theoretical outlooks and styles is beyond the scope of this paper.

With play therapy, the psychiatrist responds to the child in the language of play, by both verbal and nonverbal means.[24] This requires the psychiatrist to relearn what is often the lost language of play, which brings therapy to the level of the child within the child's own realm. Play therapy can be a viable and engaging way to approach the treatment of the younger patient.

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