# Chapter 1

# Release Play Therapy for Children with Posttraumatic Stress Disorder

Heidi Gerard Kaduson



In order to have the proper perspective on how posttraumatic stress disorder (PTSD) affects children, one must first understand what a trauma is. A psychic trauma is an emotional shock or wound that has long-lasting effects. It results when an individual is exposed to an overwhelming event and is rendered temporarily helpless and unable to use ordinary coping and defensive operations of the ego in the face of intolerable danger, anxiety, or instinctual arousal (Eth & Pynoos, 1995). There has been much research on PTSD with war veterans, but the research is minimal with regard to PTSD and play therapy (Kaduson, 2011). There are many traumatic experiences, as there might have always been: however, with technology, children are now subject to more of them than ever before.

PTSD is a psychiatric disorder that can occur following the experiencing or witnessing of life-threatening events such as military combat, natural disasters, terrorist incidents, serious accidents, or violent personal assaults like rape. Adults who suffer from PTSD often relive the experience through nightmares and flashbacks, have difficulty sleeping, and feel detached or estranged; these symptoms can be severe enough and last long enough to significantly impair a person's daily life.

Contemporary research on the biology of PTSD has confirmed that there are profound and persistent alterations in physiological reactivity and

stress hormone secretion in people with PTSD. The brain is an analyzing and amplifying device for maintaining a person's internal and external environment (MacLean, 1988), and if emotional arousal is intense and persists, as has often been experienced by trauma survivors, the person may develop conditioned emotional and biological responses with long-term effects. High levels of emotional arousal are likely responsible for the observation that traumatic experiences initially are imprinted as sensations or states of physiological arousal that often cannot be transcribed into personal narratives (van der Kolk & Fisler, 1995).

PTSD is not a new disorder. Written accounts of similar symptoms go back to ancient times. Careful research and documentation of PTSD began in earnest after the Vietnam War. The National Vietnam Veterans Readjustment Study estimated in 1988 that the prevalence of PTSD in the group studied was 15.2% at that time and that 30% had experienced the disorder at some point since returning from Vietnam (Zatzick et al., 1997).

PTSD has subsequently been observed in all veteran populations that have been studied, including World War II, the Korean conflict, and Persian Gulf populations, and in United Nations peacekeeping forces deployed to other war zones around the world. There are remarkably similar findings of PTSD in military veterans in other countries. For example, Australian Vietnam veterans experience many of the same symptoms that American Vietnam veterans experience (Creamer & Forbes, 2004).

PTSD is not only a problem for veterans, however. Although there are unique culture- and gender-based aspects of the disorder, it occurs in men and women, adults and children, Western and non-Western cultural groups, and all socioeconomic strata. A national study of American civilians conducted in 1995 estimated that the lifetime prevalence of PTSD was 5% in men and 10% in women (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995).

PTSD was formally recognized as a psychiatric diagnosis in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III; American Psychiatric Association, 1980). At that time, little was known about what PTSD looked like in children and adolescents. Today we know children and adolescents are susceptible to developing PTSD, and we know that PTSD has different age-specific features. Although a diagnosis of PTSD required the patient to have the symptoms for over a month's duration, a diagnosis of acute stress disorder, in DSM-IV (American Psychiatric Association, 1994), covers those children who have symptoms like PTSD, but for a duration of at least 2 days and less than 1 month. DSM-5 (American Psychiatric Association, 2013), refines the diagnostic criteria so that different types of traumatic events can be separated out as acute stress disorder. With this diagnosis,

> Exposure to actual or threatened death, serious injury or sexual violation occur in one (or more) of the following ways:
>
> 1. Directly experiencing the traumatic events(s).
> 2. Witnessing in person, the event(s) as it occurred to others.
> 3. Learning that the event(s) occurred to a close family member or close friend.
> 4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains, police officers repeatedly exposed to details of child abuse). (American Psychiatric Association, 2013, p. 280)

It cannot be diagnosed until 3 days after a traumatic event, although it may progress to PTSD after 1 month. Also noted in DSM-5 is that the forms of experiencing can vary across development. Unlike adults and adolescents, young children may report nightmares without content that clearly reflect aspects of the trauma (e.g., waking in fright in the aftermath of the trauma but being unable to relate the content of the nightmare to the traumatic event). Children with a mental age younger than 6 are more likely than older children to express reexperiencing symptoms through play that refers directly or symbolically to the trauma.

A diagnosis of PTSD means that an individual has experienced an event that involved a threat to his or her own or another's life or physical integrity and that this person responded with intense fear, helplessness, or horror. A number of traumatic events have been shown to cause PTSD in children and adolescents. Children and adolescents may be diagnosed with PTSD if they have survived natural or human-made disasters such as floods; violent crimes such as kidnapping, rape, murder, suicide of a parent, sniper fire, and school shootings; motor vehicle accidents such as automobile and plane crashes; severe burns; exposure to community violence; war; peer suicide; and sexual and physical abuse.

A few studies of the general population have examined rates of exposure for PTSD in children and adolescents. Results of these studies indicate that 15–43% of girls and 14–43% of boys have experienced at least one traumatic event in their lifetimes. Of those children and adolescents who have experienced a trauma, 3–15% of girls and 1–6% of boys could be diagnosed with PTSD (Giaconia et al., 1995; Cuffe et al., 1998).

Rates of PTSD are much higher in children and adolescents recruited from at-risk populations. The rates of PTSD in these at-risk children and adolescents vary from 3–100%. For example, studies have shown that as many as 100% of children who witness a homicide of a parent or sexual assault develop PTSD (Kilpatrick & Williams, 1997). Similarly, 90% of sexually abused children (Hamblen, 2004), 77% of children exposed to a school shooting (Ackerman, Newton, McPherson, Jones, & Dykman,

1998), and 35% of urban youth exposed to community violence develop PTSD (Margolis & Gordis, 2000).

Certainly not all children develop PTSD. There are, however, many factors that have been shown to increase the likelihood that children will develop PTSD:

- Quality of pretrauma attachment relationships and overall adjustment.
- Amount of social support (the more, the better).
- Type of disaster (human-made disaster leads to more PTSD than natural disaster).
- Human aggression (abuse, etc., leads to more severe symptoms of PTSD).
- Degree to which trauma is life-threatening (the less, the better).
- Parents' reactions (the less distressed, the better).
- Degree to which primary attachment figures are available and supportive.
- Communication (the more open, the better).
- Cumulative stressors (the fewer, the better).
- Degree of exposure (the more direct the exposure, the more likely PTSD).

In general, children and adolescents who report experiencing the most severe traumas also report the highest levels of PTSD symptoms. Family support and parental coping have also been shown to affect PTSD symptoms in children. Studies show that children and adolescents with greater family support and less parental distress have lower levels of PTSD symptoms. Finally, children and adolescents who are farther away from the traumatic event report less distress (Pynoos et al., 1987).

In terms of gender, several studies suggest that girls are more likely than boys to develop PTSD (Pfefferbaum et al., 1999, 2000). However, DSM-5 (American Psychiatric Association, 2013) also notes that the increased risk for the disorder in females may be attributable in part to a greater likelihood of exposure to the types of traumatic events with a high conditional risk for acute stress disorder, such as rape and other interpersonal violence. A few studies have examined the connection between ethnicity and PTSD. Although some studies find that minorities report higher levels of PTSD symptoms, researchers have shown that this is due to other factors such as differences in levels of exposure. It is not clear how a child's age at the time of exposure to a traumatic event impacts the occurrence or severity of PTSD. Some studies find a relationship; others do not. Differences that do occur may be due to differences in the way PTSD is expressed in children

and adolescents of different ages or developmental levels (Vernberg & Varela, 2001; Shelby, 1997).

Researchers and clinicians are beginning to recognize that PTSD may not present itself in children the same way it does in adults. Criteria for PTSD now include age-specific features for some symptoms (DeWolfe, 2004; Pynoos & Nader, 1993):

*Infancy through Preschool*

1. Helplessness and passivity; lack of usual responsiveness
2. Generalized fear
3. Heightened arousal and confusion
4. Cognitive confusion
5. Difficulty in talking about event; lack of verbalization
6. Difficulty in identifying feelings
7. Sleep disturbances, nightmares
8. Separation fears and clinging to caregivers
9. Regressive symptoms (e.g., bed wetting, loss of acquired speech and motor skills)
10. Inability to understand death as permanent
11. Anxieties about death
12. Grief related to abandonment by caregiver
13. Somatic symptoms (e.g., stomachaches, headaches)
14. Startle response to loud/unusual noises
15. "Freezing" (sudden immobility of body)
16. Fussiness, uncharacteristic crying, and neediness
17. Avoidance of or alarm responses to specific trauma-related reminders involving sights and physical sensations

*School-Age Children (Ages 6–11 Years)*

1. Responsibility and guilt
2. Repetitious traumatic play and retelling
3. Reminders triggering disturbing feelings
4. Sleep disturbances, nightmares
5. Safety concerns, preoccupation with danger
6. Aggressive behavior, angry outbursts
7. Fear of feelings and trauma reactions
8. Close attention to parents' anxieties
9. School avoidance
10. Worry and concern for others
11. Changes in behavior, mood, and personality

12. Somatic symptoms (complaints about bodily aches and pains)
13. Obvious anxiety and fearfulness
14. Withdrawal and quieting
15. Specific, trauma-related fears; general fearfulness
16. Regression to behavior of a younger child
17. Separation anxiety with relation to primary caretakers
18. Loss of interest in activities
19. Confusion and inadequate understanding of traumatic events most evident in play rather than in discussion
20. Unclear understanding of death and the causes of "bad" events
21. Magical explanations to fill in gaps in understanding
22. Loss of ability to concentrate and attend at school, with lowering of performance
23. "Spacey" or distractible behavior

*Preadolescents and Adolescents (Ages 12–18 Years)*

1. Self-consciousness
2. Life-threatening reenactment
3. Rebellion at home or school
4. Abrupt shift in relationships
5. Depression, social withdrawal
6. Decline in school performance
7. Trauma-driven acting-out behavior: sexual acting-out or reckless, risk-taking behaviors
8. Effort to distance from feelings of shame, guilt, and humiliation
9. Flight into driven activity and involvement with others or retreat from others in order to manage inner turmoil
10. Accident-proneness
11. Wish for revenge and action-oriented responses to trauma
12. Increased self-focusing and withdrawal
13. Sleep and eating disturbances; nightmares

Very young children may exhibit few PTSD symptoms. This may be because eight of the PTSD symptoms require a verbal description of one's feelings and experiences. Instead, young children may report more generalized fears such as stranger or separation anxiety, avoidance of situations that may or may not be related to the trauma, sleep disturbances, and a preoccupation with words or symbols that may or may not be related to the trauma. These children may also display posttraumatic play in which they repeat themes of the trauma. In addition, children may lose an acquired developmental skill (such as toilet training) as a result of experiencing a traumatic event.

Clinical reports suggest that elementary school-age children may not experience visual flashbacks or amnesia for aspects of the trauma. However, they do experience "time skew" and "omen formation," which are not typically seen in adults. Time skew refers to a child's mis-sequencing trauma-related events when recalling the memory. Omen formation is a belief that there were warning signs that predicted the trauma. As a result, children often believe that if they are alert enough, they will recognize warning signs and avoid future traumas. School-age children also reportedly exhibit posttraumatic play or reenactment of the trauma in play, drawings, or verbalizations. Posttraumatic play is different from reenactment in that posttraumatic play is a literal representation of the trauma, involves compulsively repeating some aspect of the trauma, and does not tend to relieve anxiety but to actually increase it (Terr, 1991). An example of posttraumatic play is an increase in shooting games after exposure to a school shooting. Posttraumatic reenactment, on the other hand, is more flexible and involves behaviorally re-creating aspects of the trauma (e.g., carrying a weapon after exposure to violence).

While the development and course of PTSD is well documented, there is now abundant evidence for what DSM-IV called "delayed onset" but is now called "delayed expression", with the recognition that some symptoms typically appear immediately and that the delay is in meeting full criteria (DSM-5, p. 276).

PTSD in adolescents may begin to more closely resemble PTSD in adults.

However, there are a few features that have been shown to differ. As discussed earlier, children may engage in traumatic play following a trauma. Adolescents are more likely to engage in traumatic reenactment, in which they incorporate aspects of the trauma into their daily lives. In addition, adolescents are more likely than younger children or adults to exhibit impulsive and aggressive behaviors.

Besides PTSD, children and adolescents who have experienced traumatic events often exhibit other types of problems. Perhaps the best information available on the effects of traumas on children comes from a review of the literature on the effects of child sexual abuse. In this review, it was shown that sexually abused children often have problems with fear, anxiety, depression, anger and hostility, aggression, sexually inappropriate behavior, self-destructive behavior, feelings of isolation and stigma, poor self-esteem, difficulty in trusting others, and substance abuse. These problems are often seen in children and adolescents who have experienced other types of traumas as well. Children who have experienced traumas also often have relationship problems with peers and family members, problems with acting out, and problems with school performance.

Along with associated symptoms, there are a number of psychiatric

disorders that are commonly found in children and adolescents who have been traumatized. A commonly co-occurring disorder is major depression. Other disorders include substance abuse; other anxiety disorders such as separation anxiety, panic disorder, and generalized anxiety disorder; and externalizing disorders such as attention-deficit/hyperactivity disorder, oppositional defiant disorder, and conduct disorder.

## TREATMENT INTERVENTIONS FOR PTSD

Although some children show a natural remission of PTSD symptoms over a period of a few months, a significant number of children continue to exhibit symptoms for years if left untreated. Few studies focus on PTSD treatments to determine which are most effective for children and adolescents. A review of the studies of PTSD treatments for adults shows that cognitive-behavioral therapy (CBT) is an effective approach. CBT for children generally blends both cognitive and behavioral interventions, including having the child directly discuss the traumatic event (exposure), anxiety management techniques such as relaxation and assertiveness training, and correction of inaccurate or distorted trauma-related thoughts (Berliner & Saunders, 1996; Foa & Rothman, 1998). Although there is some controversy regarding exposing children to the events that scare them, exposure-based treatments seem to be most relevant when memories or reminders of the trauma distress a child. Children can be exposed gradually and taught relaxation so that they can learn to relax while recalling their experiences. Through this procedure, they learn that they do not have to be afraid of their memories. CBT also involves challenging children's false beliefs, such as "the world is totally unsafe." The majority of studies have found that it is safe and effective to use CBT for children with PTSD (Mannarino, Cohen, & Berman, 1994; Mannarino & Cohen, 1996; March & Mulle, 1998).

CBT is often accompanied by psychoeducation and parental involvement. Psychoeducation in this case is education about PTSD symptoms and their effects. It is as important for parents and caregivers to understand the effects of PTSD as it is for children. Research shows that the better parents cope with the trauma, and the more they support their children, the better their children will function. Therefore, it is important for parents to seek treatment for themselves in order to develop the necessary coping skills that will help their children.

Psychological first aid has been prescribed for children exposed to community violence and can be used in schools and traditional settings. Psychological first aid involves clarifying trauma-related facts, normalizing the children's PTSD reactions, encouraging the expression of feelings,

teaching problem-solving skills, and referring the most symptomatic children for additional treatment (Pynoos & Nader, 1988).

Eye movement desensitization and reprocessing (EMDR) combines cognitive therapy with directed eye movements (Shapiro, 1998). Although EMDR has been shown to be effective in treating both children and adults with PTSD, studies indicate that it is the cognitive intervention rather than the eye movements that accounts for the change. Medications have also been prescribed for some children with PTSD. However, due to the lack of research in this area, it is too early to evaluate the effectiveness of medication therapy.

But what about the child who cannot "talk" about it? Such children are considered to be fine because they are not showing the symptoms in a verbal sense. Children will tend to play out traumas on their own if they can. It may be that no adult will ever see the play. However, if the support system is weak for these children (parent pathology), or if the trauma was too intense and too frequent, then they may not even attempt to play out the trauma on their own. Children do heal themselves through their play if they can. But if conditions prevent such play, then that is when release play therapy (RPT) shows the most promise and positive clinical results (Kaduson, 1997).

There has been great interest and activity over the years devoted to the study of the child's play as a basis for psychotherapy. Treating children's problems by exploiting their own methods of treating themselves has a sound basis, analogous to a study of the cure of disease by determining the organism's own methods of protection (Kaduson, 1997). Because many of the symptoms that children have are seen in their play, it is the natural course of intervention.



## THERAPEUTIC POWERS OF PLAY

One of the most important aspects of play therapy is the actual therapeutic powers of play (Schaefer, 1993). Certainly, when we are talking about PTSD, there are clear indications that the following therapeutic powers are at work in helping children assimilate a trauma and gain mastery over the event through their own means of communication, namely, play.

*Communication* is one of the most important powers of play. Play is to the child what verbalization is to the adult—the most natural medium of self-expression. Because play is the language of the child, it allows the child to "speak" to us without words. There are two types of communication: unconscious and conscious. Children play out unconscious material without direct awareness at first. They reveal thoughts, feelings, and conflicts

that they are totally unaware of. Children project their feelings onto miniature figures or puppets, thereby allowing their unconscious thoughts to rise to consciousness. Play provides a window into the otherwise invisible inner world of children. The play is "as if " it were real, so children are protected from flooding of the event when they are not ready for it. Conscious material is also communicated through play because children use their natural expression (play) to communicate events, traumas, and so forth, without using words. Play allows children to enact those thoughts and feelings of which they are aware but cannot express in words. This helps them to report their traumas in a nonthreatening way.

*Abreaction* is the reliving of past stressful events and the emotions associated with those events, even if a child could not express those emotions at the actual time of the trauma. Children use abreactive play to work through their traumas and assimilate the material a piece at a time. This concept was used by Sigmund Freud (1920/1955) to help explain how trauma victims resolve their experiences. Repressed memories are brought to consciousness and relived with the appropriate release of affect. Freud applied the concept to children, and he noted (1920/1955) that play offers young children a unique opportunity to accomplish this mental work. According to Freud, the posttraumatic anxiety can be resolved only if the therapist is able to get the child to relive the trauma with appropriate release of affect. This assimilation model fits well with the work of Piaget (1950), in that the traumatic experience is gradually assimilated into a schema (frame of reference) that is developed by the therapist–client interaction (Schaefer, 1993).

In abreaction, children have to do the opposite of what they want to do. They want to avoid processing the trauma. This can be done by (1) avoidance of knowledge of the event (amnesia), (2) avoidance of affect (numbing), (3) avoidance of behavior (phobic responses), and/or (4) avoidance of any communication about the event (Kaduson, Cangelosi, & Schaefer, 1997). Of course, the problem with such avoidance is that one cannot process the traumatic experience unless one relives it. The best way to expose young children to traumatic memories is through structured play.

Abreaction is enhanced through the act of repetition. Freud (1914/1958) maintained that children unconsciously re-create, in their play, situations related to the original traumatic event, and the frequency of the play is related to the intensity of the trauma. Therefore, every new repetition of play weakens the negative response associated with the trauma and seems to strengthen the child's sense of mastery of the event.

By means of the brief intervention of RPT, the play therapist can, in the playroom, present the child with miniature play objects representing the trauma scene and can encourage the child to play out the trauma. In this way the children can reexperience an event or a relationship in a different way, and with a more positive outcome than that of the original event. For

children to benefit from play reenactment of past traumas, a number of therapeutic processes must be present (Ekstein, 1966):

1. Miniaturization of experiences by use of the small play objects.
2. Active control and domination of events that are possible in play.
3. Piecemeal assimilation of a traumatic event by repetitiously playing out that event.

As children play in later sessions with the play therapist, different distressing details of the trauma are likely to be emphasized until, piecemeal, the event is brought into complete awareness and the reality of it accepted and integrated into the psyche.

*Mastery* is another therapeutic power of play that impels children to play out their traumas. Because play is a self-motivated activity, it tends to satisfy children's innate need to explore and master the environment (Berlyne, 1960). When children have experienced a traumatic event, their sense of efficacy is diminished. Yet through the play in RPT, children become competent and feel satisfied by their sense of efficacy.

Also at work with mastery is systematic desensitization (Wolpe, 1958). Children's play can reduce anxiety through the process of exposing them to a fearful situation while they are relaxed in play. The pleasure of play can counteract and neutralize the fearfulness, so that the children can perform the desired behavior of working through the event. The repetition of play allows for the desensitization of the traumatic experience so that the child gains a sense of power and mastery at the same time.

*Catharsis* is the release of tension and affect. It also refers to the arousal and discharge of strong emotions (positive and negative) for therapeutic relief (Schaefer, 1993). In RPT, children can release the intense feelings of anger, grief, or anxiety that have been difficult or impossible to express before, either due to the intensity of the trauma or because of the lack of a support system that would allow such expression. This discharge results in a sense of relief.

*Fantasy compensation* also allows children to create their own realities. In the world of imagination, children do not have to be satisfied with current realities or their own limitations. In RPT, children can have the power through their fantasy to compensate for their real-life weaknesses, hurts, losses, or fears and satisfy unmet needs while playing out the traumatic situation repetitively and safely in the playroom.

Pretending gives children power over their world, even when they do not have much actual control in real-life situations (Schaefer, 1993). It is the one area in which children can make reality conform to their wishes. Therefore, when they revisit a traumatic event through play, they can modify the circumstances to fill their own needs, place a support system around

themselves even if it didn't exist during the trauma, and make the ending turn out better than they experienced in the first place.

With the therapeutic powers in play, RPT can give children and adults a chance to assimilate a traumatic situation slowly and with enjoyment as they face the frightening event through their play.

## ORIGINS OF RPT

David Levy (1932) originated RPT during a time when he was observing many children experiencing the same responses to night terrors or nightmares. It was already known that children handle their own emotional difficulties through their imaginative play. When they play, they get rid of tensions arising out of anxiety. Presumably, if children's behaviors were appropriate during the event that caused the anxiety, no tension residuals would have remained (Levy, 1932). When a child's method of dealing with the anxiety is unsuccessful, symptoms of the presence of the anxiety are still at hand.

During his research, Levy found that the reasons that the children did not naturally abreact certain situations had do with a number of factors: (1) the strength of the stimulus (because fears are of varying intensity and duration); (2) the summation of events (several traumas may occur simultaneously or in close time relation); (3) the children's sensitivity to the stimulus (at different ages, different effects may occur with certain situations); (4) children may have been sensitized through a specific past experience that intensifies the response; and (5) whether any children who experienced a traumatic situation had any psychological problems prior to the event.



## TYPICAL RESPONSES TO A TRAUMATIC SITUATION

Based on the foregoing discussion, an example is used to illustrate how children naturally abreact. Although many children go through daily difficulties, it is their play and the conditions of the situation that allow them to "work it through" in their play. The following example illustrates this procedure.

Julie, a 5-year-old girl, was playing with her friend (also a 5-year-old) in the ocean close to shore. They were both jumping in the waves and screaming with delight. Julie's mom wanted to take a picture of the two children, so she walked toward the water and called for Julie and her friend to get close together for the picture. Mom was directing Julie to move a bit farther out in the ocean so that she could frame the shot better. Without

Mom's knowledge, and in a split second, Julie fell into a sinkhole in the ocean and went underwater. People around her saw this and began grabbing for her in the water. The ocean's water was not clear, so it was difficult for them to see her. Mom's immediate response was to move the camera, thinking that Julie was fooling around. In a few seconds, it was clear to Julie's mom that something had happened. She started screaming for help, and the lifeguard came quickly. He took Julie out of the water, and she immediately vomited the salt water onto the beach. Mom held her while they both cried, and then they went back to their blanket. At this point, Julie's friend was just watching from her own blanket about 5 feet away.

Mom sat on the blanket, holding Julie; then, without notice, Julie pulled away and started digging furiously in the sand to make a hole big enough to put her doll in. After she covered the doll with sand, she pulled it out again, and repeated the same action again and again while her mother watched. After about five repetitions, Julie asked her mother to get her some water. Mom just took a bucket and ran to the water's edge to scoop up the water. She filled the bucket and returned to the blanket. Julie then dug another hole, put water in the hole, and then the doll. She covered the doll completely with water and repeated this action several times. She then wanted more water, so Mom went to the ocean again and filled the bucket. During this short time, Julie's friend asked her innocently if she wanted to go back into the ocean. Julie said, "Not yet." When Mom returned again with the water, Julie took her doll, put the doll in the bucket of water, and then pulled her out quickly and made her "vomit" onto the sand. Julie repeated this three times. Then she threw her doll in the air and grabbed her friend's hand, and they both returned to the water, playing as if nothing had ever happened.

Julie was able to naturally abreact because she had all of the conditions that made it easy for her to repetitively revisit her scary situation without feeling out of control. The trauma was of short duration and intensity (although she had swallowed some water, she was never unconscious), her support system was strong (people helping immediately, as well as her mother's being right there and holding her), and this had never happened to Julie before. She was able to play it out right away without someone stopping her, perhaps by saying, "Don't worry honey, it's OK now. You don't need to do that." Whenever these words are spoken, it stops a child from doing what is naturally helpful to work through a fearful situation.

## OTHER CLINICAL ISSUES

Among the many clinical issues that must be addressed when working with children diagnosed with PTSD are countertransference and termination.

Countertransference issues are very common in treating children who have been traumatized, including, but not limited to, overidentification with the helplessness of the child and the unfairness of the circumstances, denial, excessive distancing and "vicarious traumatization." It is very important for the play therapist to remain empathic, sympathetic, and objective throughout the therapy, despite the difficulties in doing so. Supervision is helpful to ensure that personal feelings do not interfere with the therapy for the child.

In addition, RPT should be used where mastery play seems appropriate for child trauma cases. In that regard, the cases selected for this type of treatment must be "post" the traumatic incident. If the therapist suspects that there is ongoing abuse or traumatic situations may still prevail, RPT should not be used. In those cases, there are many different approaches, including, but not limited to, cognitive-behavioral play therapy (Knell, 1993; Kaduson, 2006), child-centered play therapy (VanFleet, 2010), and others. It would be inappropriate to use RPT if the child is severely depressed, resists play reenactment, shows no affect during the play, exhibits no diminution of fear reaction over the course of an exposure play session, or exhibits overvalued ideation (i.e., believes the fears are realistic) (Schaefer, 1994).

When using RPT, it is important to help keep the play focused on the traumatic situation so that the child can slowly assimilate the experience, and get to a point of mastery before termination begins. Abreactive or mastery play has been successful when two considerations are met (Caplan, 1981):

1. The play reduces to tolerable limits physiological and psychological manifestations of emotional arousal during and shortly after the stressful event.
2. The play mobilizes the child's coping resources so that the child can reduce the threat and find substitute sources of gratification for what was lost in the trauma.

To assess that the emotional processing is complete during or following play therapy, the play therapist can present relevant trauma stimuli in play or conversation to evoke an emotional reaction. If a strong negative response is elicited, it indicates that the emotional processing has not been successfully completed and further sessions are needed before termination. In many clinical cases, the child just might express that the play is finished, or he or she may seem totally disinterested in the thematic play that had been the focus of the RPT. Although rare, one-session treatment has been documented where it appears that the child just needed to be "heard."

## RPT FOR CHILDREN WITH PTSD

In order to work with a child who is diagnosed with PTSD, it is very important for the therapist to get enough information from the intake with the parents, caretakers, or whoever was present so that the therapist can help the child play through the event, rather than avoid the thoughts and feelings associated with it. Although the intake information may not be totally accurate, if the therapist can replicate the situation closely enough, children can play through the event slowly so that they can assimilate the feelings at a pace that they can tolerate. This is always a short-term approach. If the conditions are right, a child might be able to play it out in one to 10 sessions. The therapist will be very directive even while following the lead of the child. As illustrated shortly, a child may play "around" the event or withdraw from the actual play when his or her anxiety becomes too great. It is the therapist's responsibility to help the child get closer to the event, and to keep in the event, by using humor or other creative means to join the child in the experience. This can give the child more ego strength and allow for a greater feeling of safety and an opportunity to revisit something that was very scary the first time around.

It is important in RPT to remain playful and lighthearted even if the situation was so frightening that the child may have dissociated or stopped playing at all. If that happens, the child is in a severe state of PTSD. Because during the event the child felt hopeless and helpless, his or her only protection was to dissociate. This does not mean that the child cannot play about it at some time, but it does mean that at the time of the trauma, the child was frozen and experienced so much fright that he or she removed the ability to feel at all. It might not be noticed by any of the adults in the child's life, but in many cases the behavior of the child changes to one of oppositional defiance. The onset is slow, but since parents seem to fight opposition, it doesn't become an issue until there is an escalated behavior pattern. This is a common presenting problem of oppositional defiant disorder (ODD), while the underlying cause is really unknown until treatment, as will be illustrated with Martin.



## CASE ILLUSTRATION

Martin was a 5-year-old boy who was referred due to his oppositional behavior and diagnosed with ODD. His parents were seen first for the intake without Martin. They were interviewed regarding family history on both sides of the family, including grandparents, aunts, uncles, and cousins of Martin. Martin's parents had divorced 2 years earlier, but they had

maintained a good relationship and shared custody. He was an only child, and his family history was unremarkable. There was some anxiety on both sides, but nothing severe that might impact Martin directly or indirectly. During the intake both parents were asked specific questions about Martin, his sleep patterns, sensory issues, eating habits, academics and school reports, friends, relationships with peers and adults, gross motor skills, fine motor skills, and typical day in his life. All seemed to be within the normal range, although he was above "grade level," and he had started reading on his own. He goes to school in the morning, and since both parents work, he is dropped off at his paternal grandmother's house where he stays until either parent finishes work and picks him up. When asked what kind of discipline the parents used individually, both said they had tried everything, and nothing worked. He used to be easy to manage and didn't have the "terrible twos," but recently his behavior had escalated from just not doing what he was told, to become very angry and throwing things at both homes (although not with his grandmother). School had not reported any difficulties in kindergarten. After all information was gathered through this interview, the parents were given possible examples of why children become defiant, including attention getting, learned history of parental response to action, or reuniting of parents in this particular case. With that being said, Martin's parents would take parent-training sessions, if needed, as part of his treatment.

The next session was the intake for Martin. This was done with a nondirective approach, indicating to Martin that this was a special playroom, and he could do almost anything he wanted in here, and if there was something he could not do, the therapist would let him know. He entered the playroom and remarked at how many things there were to play with. He immediately gravitated to the dinosaurs, and he made an entire family with them. He said that the daddy dinosaur was the biggest, then the mommy, and last was the little one. He named that dinosaur Junior. He created two separate forests where each of the adult dinosaurs lived, and Junior would fly through the air to visit each of his parents everyday. He gave voice to Junior, but the parents were just put into their respective forests to hang out at home. Junior was the dinosaur, who made all the rules for the parents, and they had to listen to him or he would time them out. He laughed when I reflected that the biggest dinosaur was afraid of the little one, and he said both of them were afraid of Junior because he was smarter than they were. He also decided that Junior could make rain happen, and even thunderstorms, so that the parents had to get wet or run for cover. Junior was protected by his flying ability, and both parents did not know how to fly. He said that they worked at staying still. He was giving more and more power to Junior the entire session, which reflected that this was an important part of his play. He was in charge and feeling empowered by the play. After the

5-minute warning that we had to stop soon, he did put some closure on this play by saying that the sun will come out later so that the parents can come out and play or go to work. I reflected that he could make all things happen just the way he wanted them to, and he agreed. He transitioned out of the playroom very easily, and as I walked him to his mother in the waiting room, he said, "Wow, that was fun. Hey, next time let's play about when I swallowed the quarter."

Following that comment, Martin's parents were contacted so that this event could be verified. They said that because both of them work, Martin stayed at Grandma's house after preschool. Grandma, however, was wheelchair-bound, and certainly Martin was helping her out as well. One day, however, Martin did indeed swallow a quarter, and while he was having difficulty breathing, it was not possible for his grandmother to do anything but call 911. Both parents were not reachable by cell phone, although voicemail messages were left. The emergency medical team (EMT) arrived, and they took Martin to the hospital, and unfortunately, he had to go alone because his grandmother could not accompany him. He seemed very calm according to the EMT. They reported to the parents that he was very brave and handled everything well. He was only 3½ years old. I asked for the complete details of the trauma, and I explained that since his oppositional behavior began right after this incident, it was possible that this was the key to the acute onset of what was thought to be ODD. When I had reviewed the normal limitations of preschoolers, and the fact that normal behavior would be to cry, scream, or be very scared, I told them I would like to do RPT with him on the next visit to let him work through this incident other than verbally.

Before Martin entered the playroom on the following visit, I had set up an entire Playmobil hospital and ambulance, along with "Grandma's house," and the types of instruments that Martin had seen when he was taken into the hospital. His parents didn't arrive until an hour later. Martin came into the playroom, thrilled to see all of the toys, and immediately said that this will be the little boy (picking up a boy Playmobil doll with his hair color). He said that we will now play about when this boy swallowed a quarter. He put the story into third person, which is what most preschoolers would do to assimilate traumatic experiences slowly. Martin jumped into the play with ease, and when I asked what the little boy's name was, he responded, "Little boy." Martin took the little boy and put him into the ambulance first, leaving out the entire grandmother's house where the incident actually occurred. This was a red flag that the fear possibly began after the event, rather than during. As he was putting the child on the gurney, I asked him, "Is Mommy or Daddy with him?" He questioned what I said as if he never heard the words before (Mommy? Daddy?), and then recanted and said, "Oh yeah, Mommy, Mommy and Daddy are with

him." Still strapping the boy into the gurney, Martin made the sound of an ambulance siren. Then after strapping him in, he had the ambulance drive to the hospital, again making the sound of an ambulance siren.

He would start telling me about things as he played, whenever it became too frightening. So as the ambulance went to the hospital, Martin told me that the attendants in the ambulance were called "hospitalees." He interpreted this from hearing the EMT talking to each other to find out which hospital they should go to. They kept naming different hospitals, so he thought that was their names. As soon as he arrived at the emergency room, he was taken out of the ambulance, put in triage and then after x-rays they did the procedure right in the emergency room before moving Martin to his own bed in the pediatric ward. What Martin played, however, was that the little boy was put in a wheelchair, and then moved to find out "if his heart was beating." During this segment, once again the siren was the background even when he was being wheeled to different areas. He did a few medical procedures just because it was on the floor, and it was done without real knowledge about the machine. However, after they found out the heart was beating, he was taken to a hospital bed by wheelchair again, and the siren got louder and louder.

When he placed the boy in the bed, Martin became much more anxious, and began to ask me what the different items were in the playroom. I answered what he needed to hear, and waited for a few more lines and then asked if the doctor was ready to get the quarter yet? At first, he asked about a broken hospital bed, and he began to laugh at what he said, which clearly reduced his anxiety because he immediately said (in the voice of the doctor) that he was ready to get the quarter. He asked me if I knew how to do this? I began to say that I didn't, and he interrupted and said, "Oh, I know. I heard it before. You go in the bed, and the lights go out. Then they take it and the lights go on." I said that was helpful. So now he began his version of the operation, and he said to the little boy, "OK, now, open wide." I made the scared sounds of a preschooler saying "ahhhh." He smiled and took it out. Then he said, "OK, now you are done." I asked him again at this time whether the boy's mommy and daddy were with him, and at first he asked "Mommy? Daddy?" Then he said, "Oh yeah, oh yeah. They are there and they have to stay in the hospital with the little boy for 10 days without leaving." I said that it sounded like a good plan.

After this session, no more sessions were required. Both parents said that he was no longer oppositional, and he was compliant and very pleasant. He had worked it through because he did have PTSD after going in the ambulance to the hospital without anyone he knew. In the subsequent sessions, pieces of the play changed into more mastery, and his parents also received parent training for better support of Martin due to his anxiety.

## SUMMARY AND CONCLUSIONS

RPT has been clinically used successfully with type I traumas (Terr, 1991). Type I traumas are single, sudden, and unexpected. Therefore, in selecting cases suitable for RPT, it is advisable to consider the following criteria (Levy, 1938):

1. The child should be between 2 and 10 years of age (although it can work for older children with some modifications).
2. There should be a definite reactive pattern triggered by a specific stressor (e.g., a frightening experience, divorce of parents, birth of a sibling).
3. The problem should not be long-standing.
4. The traumatic experience should be in the past, not continuing at the time of referral.
5. The child should be from a relatively normal family situation.

With the foregoing criteria met, it has been shown that children do not have to know the nature of their difficulties, or of their relationship to the therapist, in order to improve. The emotional release and positive therapeutic relationship are basic therapeutic elements leading to the resolution of the trauma.

RPT has helped children resolve psychological difficulties after experiencing a traumatic experience without the appropriate support system or when the stimulus was just too strong to psychologically manage. Children were able to work through their fears, anxieties, and sadness through playing out their perceptions of what happened to them. Within weeks and sometimes within months, many children returned to their carefree childhood experiences, although at some level they had changed for good. The same is likely to happen with the victims of any traumatic event, and it is clinically proven that RPT is the treatment of choice to relieve these children of their PTSD.



## REFERENCES

Ackerman, P. T., Newton, J. E., McPherson, W. B., Jones, J. G., & Dykman, R. A. (1998). Prevalence of post traumatic stress disorder and other psychiatric diagnoses in three groups of abused children (sexual, physical, and both). *Child Abuse and Neglect, 22*(8), 759–774.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.

Berliner, L., & Saunders, B. E. (1996). Treating fear and anxiety in sexually abused children: Results of a controlled two-year follow-up study. *Child Maltreatment, 1*(4), 294–309.

Berlyne, D. E. (1960). *Conflict, arousal and curiosity.* New York: McGraw-Hill.

Caplan, G. (1981). Mastery of stress: Psychological aspects. *American Journal of Psychiatry, 138*, 413–420.

Creamer, M., & Forbes, D. (2004). Treatment of posttraumatic stress disorder in veteran and military populations. *Psychotherapy: Theory, Research, Practice, 41*(4), 388–398.

Cuffe, S. P., Addy, C. L., Garrison, C. Z., Waller, J. L., Jackson, K. L., & McKeown, R. E. (1998). Prevalence of PTSD in a community sample of older adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 37*, 147–154.

DeWolfe, D. J. (2004). *Mental health response to mass violence and terrorism: A training manual.* Rockville, MD: U.S. Department of Health and Human Services.

Ekstein, R. (1966). *Children of time and space, of action and impulse.* New York: Appleton Century Crofts.

Eth, S., & Pynoos, R. S. (1995). Developmental perspective on psychic trauma in childhood. In C. R. Figley (Ed.), *Trauma and its wake: The study of treatment of posttraumatic stress disorder* (pp. 36–52). New York: Brunner/Mazel.

Foa, E. B., & Rothman, B. O. (1998). *Treating the trauma of rape: Cognitive-behavioral therapy for PTSD.* New York: Guilford Press.

Freud, S. (1955). Beyond the pleasure principle. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 18, pp. 1–64). London: Hogarth Press. (Original work published 1920)

Freud, S. (1958). Remembering, repeating and working-through. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 145–156). London: Hogarth Press. (Original work published 1914)

Giacona, R. M., Reiknherz, H. Z., Silverman, A. B., Pakiz, B., Frost, A. K., & Cohen, E. (1995). Traumas and PTSD in a community population of older adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 34*, 1369–1380.

Hamblen, J. (2004). PTSD in children and adolescents (National Center for PTSD Fact Sheet). Available at *www.ncptsd.va.gov/facts/specific/fs_children.html.*

Hampe, E., Noble, H., Miller, L. C., & Barrett, C. L. (1973). Phobic children one and two years post-treatment. *Journal of Abnormal Psychology, 82,* 446–453.

Kaduson, H. G. (1997). Release play therapy for the treatment of sibling rivalry. In H. G. Kaduson, D. Cangelosi, & C. Schaefer (Eds.), *The playing cure* (pp. 255–273). Northvale, NJ: Jason Aronson.

Kaduson, H. G. (2006). Short-term play therapy for children with attention-deficit/hyperactivity disorder. In H. G. Kaduson & C. E. Schaefer (Eds.), *Short-term play therapy for children, second edition* (pp. 101–134). New York: Guilford Press.

Kaduson, H. G. (2011). Release play therapy. In C. E. Schaefer (Ed.), *Foundations of play therapy* (pp. 105–126). Hoboken, NJ: Wiley.

Kaduson, H., Cangelosi, D., & Schaefer, C. E. (Eds.). (1997). *The playing cure.* Northvale, NJ: Jason Aronson.

Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the National Comorbidity Study. *Archives of General Psychiatry, 52*, 1048–1060.

Kilpatrick, K. L., & Williams, L. M. (1997). Post-traumatic stress disorder in child witnesses to domestic violence. *Journal of Orthopsychiatry, 67*, 639–644.

Knell, S. M. (1993). *Cognitive-behavioral play therapy*. Northvale, NJ: Jason Aronson.

Levy, D. M. (1932). The use of play technique as experimental procedure. *American Journal of Orthopsychiatry, 3*, 266–275.

Levy, D. M. (1938). Release therapy in young children. *Psychiatry, 1*, 387–390.

MacLean, P. D. (1988). *The triune brain in evolution: Role in paleocerebal functions*. New York: Plenum Press.

Mannarino, A. P., & Cohen, J. A. (1996). Abuse-related attributions and perceptions, general attributions, and locus of control in sexually abused girls. *Journal of Interpersonal Violence, 11*, 162–180.

Mannarino, A. P., Cohen, J. A., & Berman, S. R. (1994). The Children's Attributions and Perceptions Scale: A new measure of sexual abuse-related factors. *Journal of Clinical Child Psychology, 23*, 204–211.

March, J., & Mulle, K. (1998). *OCD in children and adolescents: A cognitive-behavioral treatment manual*. New York: Guilford Press.

Margolis, G., & Gordis, E. B. (2000). The effects of family and community violence on children. *Annual Review of Psychology, 51*, 445–479.

Pfefferbaum, B., Nixon, S., Tucker, P., Tivis, R., Moore, V., Gurwitch, R., et al. (1999). Posttraumatic stress response in bereaved children after Oklahoma City bombing. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*, 1372–1379.

Pfefferbaum, B., Seale, T., McDonald, N., Brandt, E., Rainwater, S., Maynard, B., et al. (2000). Posttraumatic stress two years after the Oklahoma City bombing in youths geographically distant from the explosion. *Psychiatry, 63*, 358–370.

Piaget, J. (1950). *The psychology of intelligence*. London: Routledge & Kegan Paul.

Pynoos, R., Frederick, C., Nader, K., Arroyo, W., Steinberg, A., Eth, S., et al. (1987). Life threat and posttraumatic stress in school-age children. *Archives of General Psychiatry, 44*, 1057–1063.

Pynoos, R., & Nader, K. (1988). Children who witness the sexual assaults of their mothers. *Journal of the American Academy of Child and Adolescent Psychiatry, 27*, 567–572.

Pynoos, R., & Nader, K. (1993). Issues in the treatment of posttraumatic stress in children and adolescents. In J. P. Wilson & B. Raphael (Eds.), *International handbook of traumatic stress syndromes* (pp. 535–549). New York: Plenum Press.

Schaefer, C. E. (1993). What is play and why is it therapeutic? In C. E. Schaefer (Ed.), *The therapeutic powers of play* (pp. 1–5). Northvale, NJ: Jason Aronson.

Schaefer, C. E. (1994). Play therapy for psychic trauma in children. In O'Connor, K. and Schaefer, C.E. (Eds.), *Handbook of play therapy, Volume Two: Advances and innovations* (pp. 291–318). New York: Wiley-Interscience.

Shapiro, F. (1998). *EMDR: The breakthrough therapy for overcoming anxiety, stress and trauma*. New York: Basic Books.

Shelby, J. S. (1997). Rubble, disruption, and tears: Helping young survivors of natural disaster. In H. Kaduson, D. Cangelosi, & C. E. Schaefer (Eds.), *The playing cure* (pp. 143–169). Northvale, NJ: Aronson.

Terr, L. (1991). Childhood traumas: An outline and overview. *American Journal of Psychiatry, 148*, 10–20.

van der Kolk, B. A., & Fisler, R. (1995). Dissociation and the fragmentary nature of traumatic memory: Background and experiential evidence. *Journal of Trauma Stress, 9*, 505–525.

Van Fleet, R. (2010). *Child-centered play therpay*. New York: Guilford Press.
Vernberg, E. M., & Varela, R. E. (2001). Posttraumatic stress disorder: A developmental perspective. In M. W. Vasey & M. R. Dadds (Eds.), *The developmental psychopathology of anxiety* (pp. 386–406). New York: Oxford University Press.
Wolpe, J. (1958). *Psychotherapy by reciprocal inhibition*. Stanford, CA: Stanford University Press.
Zatzick, D. F., Marmar, C. R., Weiss, D. S., Browner, W. S., Metzler, T. J., Golding, J. M., et al. (1997). Posttraumatic stress disorder and functioning and quality of life outcomes in a nationally representative sample of male Vietnam veterans. *American Journal of Psychiatry, 154*, 1690–1695.





Guilford Publications
370 Seventh Avenue, Suite 1200
New York, NY 10001
212-431-9800
800-365-7006
www.guilford.com