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PLAY THERAPY WITH CHILDREN WHO HAVE BEEN ABUSED OR NEGLECTED

BY

CLAIRE MILGROM

A Practicum Report
Submitted to the Faculty of Graduate Studies
In Partial Fulfillment of the Requirements
For the Degree of

MASTER OF SOCIAL WORK

Faculty of Social Work
University of Manitoba
Winnipeg, Manitoba

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Play Therapy with Children who have been Abused or Neglected

BY

Claire Milgrom

A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University of Manitoba in partial fulfillment of the requirements of the degree of Master of Social Work

CLAIRE MILGROM©1999

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ACKNOWLEDGEMENTS

I would like to express my enormous appreciation to:

The four lovely children who came to spend time with me in the playroom over the past 16 months and found a niche in my heart.

The children's caregivers that were an integral part of the treatment team.

My advisor, Dr. Diane Hiebert-Murphy, especially for reading the draft of my practicum report while on holidays.

My direct clinical supervisor and committee member, Ms. Linda Perry, for her sensitive, kind and practical guidance in working with the children and their families.

My committee member, Dr. Linda Rhodes, for her support and encouragement in becoming a play therapist.

Elizabeth Hill Counselling Centre staff, Ms. Susan Herring, Ms. Nicole Miller and Ms. Arlene Baunsit, for welcoming the children and their families to the Centre so warmly, helping to put smashed dollhouses back together, and sharing the highlights and challenges of my practicum with me.

Dr. Charlie Ferguson, Director of the Child Protection Centre, for supporting my learning both personally and professionally by allowing me to pursue my education at times during the work day.

My friends for their interest and encouragement, and their patience on those days I was "distracted and scattered."

And especially to my partner, Rhonda Appleyard, for living and breathing this practicum process with me from start to finish.

In the dark, I would wander off. Eyes open, unseeing. I would think about the sounds of the fight, trying to know who was getting hit where and how. I used to feel bad about having made a game of my mother's pain. Now I know that children have to play. They make games of whatever life presents them with. If life gives them agony to play with, the games of children will be cruel jokes on the people that chart their lives.

Lee Maracle

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ABSTRACT

Children who have been abused or neglected are at risk of compromised development physically, emotionally, cognitively, sexually and socially. Compromised development can negatively affect their ability as children, adolescents and adults to function positively and effectively in their environments. The focus of this practicum was the provision of play therapy for children who had experienced abuse or neglect. The practicum experience included working with four children under the age of 12 on a weekly basis for approximately one year. A review of the literature regarding the definition of play, play therapy models and techniques, abuse and neglect of children, and issues of working with children in care, is provided. Two case examples are described including an evaluation of the outcomes using standardized measures. Clinical themes relevant to play therapy with children who have been abused or neglected are discussed and include the therapeutic relationship; transference; loyalty to parents; anger, anxiety and aggression; developmental issues; and systemic issues.

INTRODUCTION

I graduated from the University of Manitoba in 1988 with a Bachelor of Social Work degree. For the last 12 years, I have been working in the field of child welfare, initially as a Child and Family Services social worker in the core area of the city. Subsequent to this experience, I worked for approximately five years at a residential treatment facility for adolescent girls as a clinical case manager. I then worked for three years at the Child Protection Centre where my main responsibility was the completion of parent-child assessments.

While prior to my play therapy practicum, there was most certainly a therapeutic component to my work with children, youth and families, my focus up until that time was on assessment, investigation, protection and case management. In order to feel more "well-rounded" in both my knowledge base and skill level I wanted to develop my clinical skills through the practicum process.

Specifically, I wanted to become competent in providing play therapy for children who were experiencing pain, anxiety, fear, sadness, anger, low self-esteem and attachment difficulties due to a variety of life circumstances. In keeping with my child welfare experience to date, I chose to focus my practicum experience on children who have suffered emotional, physical or sexual abuse, or neglect.

My learning objectives were as follows:

1) To become knowledgeable about the different play therapy models, and competent in the provision of play therapy with children under the age of twelve who have suffered from abuse, neglect or loss using various models and techniques. As Schaefer and O'Connor (1983) note in their introduction

to the Handbook of Play Therapy, not all play therapy techniques are effective with all types of clients and in all types of situations. They suggest that a prescriptive approach "emphasizes the therapist's responsibility to determine the most appropriate therapeutic technique for each particular case" (p. 1).

2) To become competent in offering support and education to caregivers of children who are engaged in play therapy while still respecting the child-client, adult-therapist relationship.

3) To become more knowledgeable in the area of child abuse and neglect especially in terms of being able to differentiate between normative childhood behaviour and behaviour which is of concern.

LITERATURE REVIEW

Theories of Play Behaviour: An Overview

The scientific study of play behaviour began in the nineteenth century and has yielded numerous definitions of, and explanations for, this phenomenon. These theories can be divided into four general categories: biological, psychoanalytical, developmental and cultural.

Biological Theories of Play

Early theorists in the late nineteenth and early twentieth centuries tended to define play behaviour in biological terms. In 1875, Schiller described play as "the expression of superfluous energy" (cited in Bronstein, Krikorian, & Wiener, 1964, p. 387). Spencer (1901), too, subscribed to such a theory. In addition to their belief that play was the result of a surplus of energy that was no longer needed for basic survival, these theorists based their concept on the premise that human beings were innately active organisms. Play, then, was the natural consequence of an automatic channeling of energy after basic survival needs had been met.

A criticism of the surplus energy theory of play is its failure to distinguish between the structure and characteristics of different forms of play behaviour (Levy, 1978). A second criticism of the theory is the observation that not all play behaviour is "aimless" and, indeed, may fulfill very specific functions either within the process of the play behaviour itself or in the pursuit of the play behaviour goal (Levy, 1978). A third criticism of the theory is provided by Smilansky (1968) who worked with socioculturally deprived children in Israel and discovered differences in the play forms among

sociocultural groups. Consequently, she rejected the notion of a universal "play drive" motivated by a "surplus reservoir of energy". Specifically, she wrote:

> Schiller's theory cannot satisfactorily account for the fact that 'play drive,' a phenomenon common to all children, does not provide a basic source of play behavior for under-privileged children, as it does for children from high sociocultural backgrounds. According to Schiller, children manage, through their 'play drive,' to free themselves from the shackles of reality. We found no hint in Schiller's theory that could explain why some children (underprivileged) do not achieve this freedom. (p. 49)

A fourth criticism of the surplus energy theory was provided by Beach (1945) and Groos (1901) who both noted that physical energy cannot be stored and that, furthermore, play behaviour can be observed in both animals and children even when a surplus reservoir of energy is not apparent.

In contrast to Schiller and Spencer's theory, Lazarus (1883) proposed the recreation theory of play behaviour, that is, that play is the result of the individual's need to overcome a deficit of energy. Alderman (1974) notes that this theory fails to explain play not preceded by mental fatigue, nor does it distinguish between the different structural dimensions of various forms of play. However, it does contrast work behaviour (characterized by its seriousness, its explicit purpose, goals and measurable end product, and its tendency to cause physical and mental strain) with play behaviour whereby the latter "alleviates boredom and psychological tension but also seems to

replenish one's physical stores" (Alderman, 1974, p. 30). The main criticism of Lazarus' recreation theory of play is its failure to address the interactional differences in various work and play environments, and various people. However, in general terms, the theory appears to have some validity; few people would disagree that play experiences can make people feel better prepared both psychologically and physically for a return to work.

In 1901, Groos went on to develop what has come to be known as the pre-exercise theory of play. According to Groos (1901), play is defined by the emergence of incomplete hereditary instincts. Through play, crude instincts are practiced and honed for the struggle to survive. The assumptions underlying the pre-exercise theory of play include a belief in the evolution of the human species through natural selection and the resultant survival of the fittest, and the belief that child play is the opportunity to overcome an "insufficient hereditary endowment" for this purpose. Groos (1901) postulated that human beings needed a stage in their developmental process characterized by "playful experimentation" which would allow them to master the senses of survival, such as smell, touch, hearing, motor kinesthesis, and ocular discrimination (Groos, 1901).

Smilansky (1968) outlines the shortcomings of this theory in terms of its naïve overemphasis on the innate biological determinants of play. She states:

> Under-privileged children, too, have instincts; why do they not train and strengthen their instinctual tendencies ... through the experience that play activity affords? Where do these children acquire the necessary training to strengthen and support their chances of survival in adult life? (p. 51)

Another difficulty with the pre-exercise theory of play behaviour is its assumption that human beings, based on the past and present, are capable of knowing what survival skills will be needed in the future. Levy (1978) notes that this is both impossible and impractical given the rapidly changing characteristics of life as we approach the 21st century.

Hall (1906) defined play as the recapitulation of the various phylogenetic stages that have preceded the human species on the evolutionary scale, that is, Insectivora, Carnivora, Hyaendonta, Taeniodonta and so forth. The underlying tenet of this theory is the belief in children as an evolutionary link between present-day human beings and all prior cultural stages of the human race. Children, by way of their play, recapitulate the behavioural traits that made past survival possible (e.g., climbing, swinging, throwing, catching, running and yelling) without compromising the cultural and social progress of human culture.

Smilansky (1968) has criticized Hall's theory of play behaviour for its failure to recognize the impact of environmental and socio-cultural factors on play behaviour. Ellis (1973) further criticizes this theoretical concept as it does not explain "the intense interest of man in toys that utilize contemporary technology, such as slot cars, dirt bikes, chemistry sets, and talking dolls" (p. 44).

In 1916, T.W. Patrick extended Lazarus' earlier recreation theory of play speculating that play stems from a need for relaxation. Specifically, he felt that play is the result of the adult human being's need for gross motor activities that are generally not undertaken due to the tendency of adult human beings to engage predominantly in activities which rely on the small muscles. Patrick (1916) went as far as to equate play

behaviour with the need to satisfy human beings' old "racial pursuits" (p. 49) inherited from their evolutionary past, and the need to escape from an artificial type of life comprised of human artifacts.

While Patrick's theory of play behaviour supports the need for recreational activity for both children and adults, there is no scientific evidence to support his notion of "racial pursuits" inherited from an evolutionary past. Furthermore, his theory overlooks the fact that there is a cognitive component to gross motor activity in both adults and children.

It is apparent that these early theorists sought to understand play behaviour within a framework of biological evolution, however, as Slobin (1976) notes, these theories only attempt to explain "why the child plays as opposed to doing nothing or doing other things, and attempts ... to explain the energy source of this activity" (p. 101). He observes that these theories are not helpful in explaining the choice of play activities, and further adds that they limit the range of play behaviour to the exercise of a vaguely defined and outdated concept of a biologically fixed and localizable set of "faculties". Additionally, Beach (1945), and Witt and Bishop (1970) criticize these theories for their basis on observational evidence rather than empirically derived scientific knowledge.

Psychoanalytic Theories of Play

In the twentieth century, Sigmund Freud's psychoanalytic theory has provided the basis for an understanding of both children's play behaviour and play therapy with children in a developmental context. It will be discussed here separately from other developmental models because of its significant contribution to the literature on human behaviour.

Freud's theory describes mental functioning as taking place on two levels - the primary processes and the secondary processes - that he states are antagonistic to one another. The primary processes originate from sexual and aggressive drives which are uncontrolled and include unconscious thought such as dreaming, symbolization and displacement, all of which largely determine human behaviour (as cited in Jennings, 1993). They are, furthermore, connected to Freud's theory of the pleasure principle. The secondary processes are logical and rational and seek to keep in check the unbridled expressions of the unconscious. They are connected to the reality principle, that is, the demands of the real and outside world.

According to the theory, the interaction of these processes is mediated by a tripartite personality structure consisting of the id, the ego and the superego. The id, driven by biological forces (including sexual desires and feelings of aggression), is the part of the personality that seeks to gratify basic needs. The superego is the internalization of parental and social rules that attempts to restrict the id and enforce conformity as prescribed by these sources. The ego is the portion of the personality that mediates between the id and the superego. According to Freud, a child's healthy development is characterized by the development of a healthy ego capable of regulating and setting parameters around the pleasure-seeking, instinctual id. This can only be accomplished once a child has successfully moved through the early psychosexual stages of oral, anal, and phallic pleasure gratification. The final psychosexual stage of development is characterized by the Oedipus Complex for boys and the Electra Complex for girls, which both involve an attempt by children to resolve their sexual conflicts regarding their parents.

Freud postulated that as long as a child's basic needs are met and the child does not experience any significant trauma, personality development proceeds in an orderly manner culminating in the formation of a stable relationship with a partner of the opposite sex in late adolescence or early adulthood. Conversely, pathology results from one or more of the personality structures failing to develop because of an experienced trauma, because of needs going unmet, or from a conflict between the basic structures (as cited in O'Connor, 1991, p. 17).

Cattanach (1992) provides an excellent summary of Freud's theory as it applies to the concept of play. She writes:

> The repetition of symbolic games which children invent for themselves are the ego's attempt to repeat actively a traumatic event which was earlier experienced passively, so the child can gain mastery over the event. ... Children repeat in their play everything that has made a great impression on them in actual life, that they thereby abreact the strength of the impression and so to speak make themselves masters of the situation. (p. 37)

Eric Erikson (1950) expanded on Freud's theory of biology and instinct as determinants of human behaviour, to include an examination of the interactive role of the human social environment with the biological makeup of the individual in the shaping of human behaviour. Furthermore, Erikson's theories, unlike Freud's, span the whole life cycle demonstrating human development beyond the resolution of the Oedipus/Electra Complex.

Erikson (1968, 1980) went on to develop two major paradigms in his discussion of human development. The first paradigm comprised a set of universal stages through which all human beings pass and during which time they are vulnerable to conflicts, anxieties and guilt that may arise from an interaction between biological needs and the environment. These stages are:

- Trust Vs. Mistrust
- Autonomy Vs. Shame/Doubt
- Initiative Vs. Guilt
- Industry Vs. Inferiority
- Identity Vs. Identity Diffusion

Specifically regarding play, Erikson's second major interactive paradigm focuses on the stages of infant development which bring the child gradually into more contact with a wider sphere of interpersonal contacts. The first stage, called the autocosmic stage, is the most primitive phase of human development. During this time, the child is egocentric, having not yet learned to distinguish him- or herself from others. The child's play, then, is characterized by a focus on the body and is exploratory and reflexive in nature. The second stage, the microcosmic stage, sees the child beginning to appreciate the distinctions between self and others, and learning to interact with other children. The macrocosmic stage, the third stage of infant development, is characterized by the child's understanding of the consequences of his or her actions, his or her ability to accommodate to the social and environmental system, and his or her subsequent ability to interact in a meaningful way with adults. Based on the premise that each of these stages is also endowed with crises and resolutions, and that childhood involves one mastery after

another, Erikson (1968) viewed play in this regard as fulfilling a major function in the development of the human race.

Theories proposed by Winnicott also have their foundation in classical Freudian thought. Winnicott (1975) focuses attention on the role of "transitional phenomena" (e.g., blankets, soft toys) in children's development for assisting them in separating from their mothers in the early years of life. This process of individuation is further developed by a "transitional space" between mother and child, that is, the place in which meaningful communication transpires. Play is the direct antecedent of transitional phenomena followed by shared playing and cultural experiences. Winnicott (1975) describes play as a unique and creative experience formulated by children from a combination of inner personal reality and external reality.

Psychoanalytic theory has been sharply criticized in the latter part of the twentieth century for its sexism (Herman, 1992), lack of empirical support (Ellis, 1973) and the fact that its principles were derived from work with emotionally disturbed individuals and are, thus, not necessarily applicable to the general population (Smilansky, 1968). Nevertheless, psychoanalytic theory contributes significantly to the literature regarding human development in recognizing subconscious thought, aggression, sexual drive and trauma in shaping human behaviour. Additionally, psychoanalytic theory acknowledges, albeit in a rudimentary manner, the significance of the parent-child relationship in human development.

Other Developmental Theories of Play

In the early 1950's, Piaget began studying play behaviour extensively and concluded that it created both pleasure or joy for its participants as well as a learning

opportunity for them to experiment with new social, physical, cognitive, and emotional patterns that cannot otherwise be accommodated in the real world. He also concluded that children's development is accomplished through interaction with the environment using two complementary processes, assimilation and accommodation (Piaget, 1952). Assimilation is defined as the bending of external reality to fit the child's current cognitive view of the world. Accommodation is defined as the adjustment of the child's worldview to fit external reality. When the process of assimilation predominates, Piaget (1962) noted that a child was likely playing.

According to Piaget (1952, 1962), as an individual vacillates between these two behavioural processes, she or he also progresses through four major bio-social-cognitive stages of development: sensorimotor, preoperational, concrete operational and formal operational. He believed that mastery of the tasks in one stage of development was a prerequisite for advancing into following stages.

Children's play is characterized by "practice" in the sensorimotor stage (birth to two years) during which time they attempt to understand the environment only in the context of basic survival needs. Symbolic play emerges in children entering the preoperational stage (ages two to seven) during which time two separate but equal realities are apparent for them (i.e., fantasy and reality). In the concrete operational stage (ages seven to twelve), children's play becomes social as they begin to become more aware of their environment and its implications. Finally, as children enter the formal operations stage (twelve and over), their use of make-believe diminishes drastically as they become integrated into adult reality through their newly acquired abstract thinking abilities (Piaget, 1952, 1962).

Smilansky (1968) later revised Piaget's original developmental categories into specific stages of play: 1) functional play (sensorimotor), 2) constructive play (manipulation of environment and objects to create something), 3) dramatic play "(let's pretend)", and 4) play with rules of conduct and procedure. However, while generally endorsing his views, she also provides strong evidence that Piaget's invariant sequential developmental stages of play may not be a universal phenomenon. Extrapolating from her 1968 study of culturally deprived and culturally advantaged Israeli children, she concluded that environmental factors such as culture and child-rearing practices have a great amount of influence on the quality and sequencing of the developmental stages of play. Smilansky (1968) also interpreted the function of symbolism in children's play somewhat differently than Piaget, concluding that play, rather than declining with age, takes on a more elaborate form.

Sutton-Smith (1966) concurs with Smilansky on this latter point stating that,

> Though the preschool egocentric symbolic play may decrease with age, play nevertheless finds expression in the midst of a variety of other cultural and social forms. It is thus not displaced by realism or by greater rationality, nor does it cease to be a vital function with age. Instead it becomes more differentiated and more representative in its contents of the other forms of human development. Without such a point of view it is difficult to understand the verbal play of adults, their social and sexual play, their rituals and their carnivals, their festivals

> and fairs, and their widespread and diversified
>
> playfulness. (p. 109)

Other criticism of Piaget's work suggests that he focuses on the cognitive development of children without paying attention to their emotional development. For example, Lahad notes that a child may be able to meet certain developmental milestones within the logical sphere of operations, but may have few coping skills in the affective areas (cited in Jennings, 1993, p. 11).

Some theorists, building on Piaget's work, have examined how children use symbolic play to represent their social world. While acknowledging Piaget's theory as revolutionary, Bretherton (1984) notes that, despite observing otherwise, Piaget emphasized the "incoherence of pretending" (p. 3). In contrast, Bretherton (1984) believes that children, depending on their developmental level, adopt roles and create scripts "to create a fictive reality that does not merely simulate but transforms their affective cognitive map of the social world" (p. 8). In 1977, Garvey and Berndt defined symbolic play as "the creation of subjective realities in which children can experiment with symbolic interactions to reality and play creatively with these alternatives" (cited in Cattanach, 1992, p. 34). In their work, they also documented the manner in which children regulate the content and process of their pretend play.

Other theorists and practitioners such as Cook (1917), Slade (1954), Way (1967), Heathcote (1980), and Bolton (1979), discuss play behaviour in terms of drama and creativity. An innovator in the field of educational drama, Cook (1917) stated his belief that experience led to learning, that acting was a way to learn and that play was the natural means of study. In 1954, Slade published his theory, methodology and practice

for drama work with children and adolescents in Child Drama. Slade defined children's drama as an art form and the child as a natural actor. He distinguished between children's personal play, in which the whole self is used in movement and characterization, and projected play, in which less physical activity is involved but the mind is used to project dramatic scenarios onto external objects. According to Slade (1954), art, reading and writing are developed from projected play.

Both Way (1967) and Bolton (1989), working in the field of education, concluded that drama is fundamental in the development of individuals. Bolton (1989), specifically, saw drama as offering an opportunity to teach the possibility of change in the value of any given situation or concept thus validating the personal meanings such situations or concepts have for children. The work of Heathcote (1980) developed the idea of drama as a social activity, seeing its function as problem solving in that children are able to experiment without future repercussions or worrying about the inherent dangers of real life.

More recently, play therapists such as Brems (1993) have categorized the purposes of play as self-development, maturation and relationship development. In terms of self-development, children use play to express their feelings and thoughts, to explore their interests, and to gain a sense of control over their environment. In terms of the maturation process, play can be used to develop motor skills, cognitive skills, language skills, and problem-solving skills, which in turn, allows children to learn about their environments. Finally, playing with others with a variety of play materials can enhance children's social skills and ability to empathize with others.

In summary, developmental theories of play behaviour have contributed significantly to our understanding of human behaviour by studying the complex interplay between human beings' biological maturation processes and the environment. This understanding has been incorporated into many educational and therapeutic models of intervention as a means of enhancing optimal functioning in children and adults.

A Cultural Theory of Play

Huizinga's (1955) classic observations of play do not appear to fit any of the above categories. They are far more reaching than those of the other theorists as he places play behaviour in the category of a cultural and historical phenomenon. According to Huizinga, play is characterized as standing separately from normal life, as being "not serious" in nature but as simultaneously absorbing the participant, as unconnected with material gain, and as proceeding with its own boundaries of time and space in an orderly manner according to fixed rules.

Huizinga (1955) considered play as defined in this manner to be a function of culture from its earliest beginnings; that play is a cultural factor in life; and that the spirit of playful competition is, as a social impulse, older than culture itself, pervading all aspects of life. Specifically, he writes of ritual, poetry, philosophy, rules of warfare and the conventions of noble living all deriving from some aspect of play. According to Cattanach (1992), Huizinga further suggests that play "has endured as a newfound creation of the mind retained by the memory ... it was transmitted, it became tradition" (p. 30).

Summary

The various theories of play behaviour that have been proposed since the late nineteenth century appear very much to have been influenced by current attitudes in scientific thinking. For example, proponents of play as a biological phenomenon wrote at a time in which Social Darwinism was emerging as legitimate scientific theory. Freud's psychoanalytic thinking influenced much of the twentieth century's views about human nature in terms of human beings' sexual drive, aggression and consciousness. It is not surprising, then, that Freudian thinking has been applied to the play of children in their acting out of both their conscious and unconscious feelings and conflicts.

As the influence of Freudian thinking began to wane, many social scientists began to explore more thoroughly play and children's development in the context of children's interaction with their environment. Play, then, is seen as an essential part of children's growth, relationship with others, and mastery of their environment. Play therapy, in turn, can enhance a process that is already a natural part of children's development. When children's development has been compromised because of abuse or neglect, play therapy can be used as a corrective and restorative process. For an optimal understanding of children's play and the process of play therapy, it would seem most useful to use an ecological model that acknowledges biological, developmental, psychological, environmental and cultural influences.

Play Therapy: An Overview

Solomon (1940) recognized five therapeutic values of play therapy:

1) release of hostility toward parents, siblings, etc.;

2) alleviation of guilt feelings;

3) opportunity to express freely all love fantasies;

4) incorporation of therapeutic suggestions in direction of growth; and

5) desensitization by means of repetition. (p. 763)

Amster (1943) suggested that there are six specific uses of play with children in treatment:

1) Play can be used for diagnostic understanding of the child.

2) Play can be used to establish a working relationship.

3) Play can be used to break through a child's way of playing in his daily life and his defenses against anxiety.

4) Play can be used to help a child act out unconscious material and to relieve the accompanying tension.

5) Play can be used to help a child verbalize conscious material and to relieve accompanying tension.

6) Play can be used to develop a child's play interest, which he can carry over into his daily life and which will strengthen him for his future. (pp. 62-67)

More recently, Schaefer (1993) proposed a taxonomy of overlapping therapeutic play properties that may have one or more curative functions. The factors (with potential curative functions in parentheses) include: overcoming resistance (working alliance), communication (understanding), competence (self-esteem), creative thinking (innovative solutions to problems), catharsis (emotional release), abreaction (adjustment to trauma), role-play (practice and acquiring of new behaviours, empathy), fantasy/visualization (fantasy compensation), metaphoric teaching (insight), attachment formation

(attachment), relationship enhancement (self-actualization, self-esteem, closeness to others), positive emotion (ego boost), mastering developmental fears (growth and development) and game play (ego strength, socialization) (pp. 1 – 15).

White and Allers' (1994) recent study of the various play therapies revealed that the majority of clinicians define their work in terms of Axline's (1947, 1964) or Landreth's (1981) child-centred approaches (pp. 392-393). Others use a more specific approach such as Jernberg's Theraplay (1979). Individual contributions to the literature generally focus on the theoretical orientation of a play therapy model (e.g., cognitive-behavioural, psychoanalytical), a particular technique (e.g., sand tray therapy, music therapy) or a particular population (e.g., children who have been abused, children with chronic illness). The following is an overview of play therapy models and techniques:

Play Therapy Models

Psychoanalytic Play Therapy

Initially, it seems that psychoanalytic therapists working with children in the early twentieth century tended to use play only indirectly (Freud) or primarily as a means of building rapport with child clients (Anna Freud, Hug-Hellmuth). In contrast, Klein believed children's verbal skills insufficient to express abstract thought and feeling, and, consequently, used therapeutic play as a direct substitution for language. In keeping with her psychoanalytic framework, Klein interpreted her clients' play activities into "the presumed language of the unconscious" (cited in Schaefer & O'Connor, 1983, p.11). More recently, Esman (1983) reiterates the focus of play in psychoanalytic child therapy as allowing for the "communication of wishes, fantasies, and conflicts in ways the child can tolerate affectively and express at the level of his or her cognitive capacities" (p. 19).

The general goal of psychoanalytic play therapy is the development of insight via the transference relationship with the therapist and therapist-generated interpretation of the child's play. Schaefer and O'Connor (1983), in their critique of this approach, note that a child's capacity for insight is limited. Furthermore, the development of insight does not necessarily result in behavioural changes. They also point out that therapists are not always accurate in their interpretations of a child's play.

Freedheim and Russ (1983) suggest that "insight-oriented therapy is appropriate for children who have good overall ego development, can tolerate anxiety, are struggling with internal conflicts, trust adults, and are able to think about their behaviour and what it means" (p. 984). Consequently, the population of children that can benefit from this type of therapy would appear to exclude very young children, children experiencing attachment difficulties and children who have been traumatized by chronic or severe abuse.

Structured Play Therapy

More approaches to play therapy began to develop in the 1930's based on the concept that play is an essential part of child analysis. Structured play therapy, based on the tenets of psychoanalytic theory, was a goal-oriented approach which underscored a belief in the cathartic value of play and a belief in the active role of the therapist in determining the focus and course of treatment (Schaefer & O'Connor, 1983, p. 6). For example, one type of structured play therapy developed by Levy (1938) and referred to as "release therapy" involved providing a child with specific play materials likely to direct him or her into recreating an event which had been traumatizing. Using psychoanalytic principles, Levy believed that the repetitive recreation of the traumatic event in a safe,

supportive environment would enable a child to assimilate his or her associated negative thoughts and feelings. In 1955, Hambridge worked with children in a similar manner to Levy, however, after the client-therapist relationship was solidified, he directly, rather than indirectly, recreated the event or anxiety-producing life situation for the child (Schaefer & O'Connor, 1983, p. 6).

Another type of structured play therapy, called active play therapy, was developed in 1938 by Solomon and was intended for use with impulsive/acting-out children. According to Solomon, the goal of active play therapy is to help a child express fear and rage through the medium of play, creating an abreactive effect, as the child is able to act out without fear of negative consequences. Solomon also believed an important part of active play therapy to be the clarification for the child between the anxiety caused by past traumas and the reality of his or her present circumstances (cited in Schaefer & O'Connor, 1983).

Relationship Therapies

Other approaches to working with children generally referred to as relationship therapies also began to emerge in the 1930's based on the work of Otto Rank (1929) who de-emphasized the importance of transference and the examination of past events in therapy and focused, instead, on the client-therapist relationship and on the current circumstances of the client. The primary foundation of Rank's work is his belief that people's fear of individuation which, in turn, causes them to cling to the past, is based on the stress of the birth process. Therapists such as Taft (1933), Allen (1942, 1973) and Moustakas (1953, 1973) adapted Rank's work for play therapy with children

emphasizing the safety of the child-therapist relationship in order to allow the child to meet his or her therapeutic goals.

Non-Directive Child-Centred Play Therapy (Axline)

In 1947, Virginia Axline developed her now well known and respected non-directive client-centred play therapy techniques. Based on the idea that play is children's natural medium of communication, Axline further believed that all children strive for growth. The purpose of client-centred play therapy, then, is to create an environment to promote this natural process which has been thwarted in emotionally damaged children. The basic rules of Axline's play therapy techniques are as follows:

1) The therapist must develop a warm, friendly relationship with the child. Good rapport should be established as soon as possible.

2) The therapist accepts the child exactly as he or she is.

3) The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his or her feelings completely.

4) The therapist is alert to recognize the feelings the child is expressing and reflects those feelings back in such a manner that the child gains insight into his or her behaviour.

5) The therapist maintains a deep respect for the child's ability to solve his or her own problems if given an opportunity to do so. The responsibility to make choices and to institute change is the child's.

6) The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way, the therapist follows.

> 7) The therapist does not attempt to hurry the therapy along. It is a gradual process and must be recognized as such by the therapist.
>
> 8) The therapist only establishes those limitations necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship. (Axline, 1947, pp. 73-74)

Limit-Setting Play Therapy

While Axline (1947, 1964) proposed establishing only fundamental limits as a background to the accomplishment of therapeutic goals, other therapists such as Bixler (1949) and Ginott (1965) saw the setting of limits as a primary vehicle of change in therapy sessions. According to Schaefer and O'Connor (1983):

> The rationale in limit-setting therapy is that children who manifest specific acting-out behaviour can no longer trust adults to react in consistent ways and therefore must constantly test their relation to adults. Limits allow the child to express negative feelings without hurting others and subsequently fearing retaliation. Further, limits allow the therapist to maintain a positive attitude toward the child because he or she does not feel compelled to tolerate the child's aggressive acting out. (p. 8)

Filial Therapy

Bernard Guerney, Jr., developed another form of play therapy, filial therapy, in 1964. More recently it has also been referred to as Child Relationship Enhancement Family Therapy (CREFT). In filial therapy,

> parents become the primary change agents as they learn to conduct child-centred play sessions with their own children. Filial therapists, using a competence-oriented psycho-educational framework, teach parents to conduct specialized play sessions, supervise parents during these play sessions, and help them eventually integrate the play sessions and parenting skills at home. (VanFleet, 1994, p. 2)

Filial therapy is not recommended as an intervention method with parents who are intellectually compromised, overwhelmed with their own needs, who have abused their own children or failed to protect them from the other parent.

Theraplay

In further contrast to Axline's client-centred approach, Theraplay is a set of therapeutic techniques developed by Ann Jernberg (1979) based on the principles of structuring, challenging, intruding and nurturing - all, according to Jernberg, essential parental behaviours in promoting both attachment and autonomy in children. She gives the following examples:

> *1) Structuring.* The mother limits, defines, forbids, outlines, reassures, speaks firmly, labels, names clarifies, confines, holds, and restrains her baby.

> *2) Challenging*. The mother teases, dares, encourages, varies, chases, and plays peek-a-boo with her baby. She offers her cheeks for grabbing, makes noises for imitating, and wiggles her fingers for catching.
>
> *3) Intruding*. The mother tickles, bounces, swings, surprises, giggles, hops at, and pounces on her baby.
>
> *4) Nurturing*. The mother rocks, nurses, holds, nuzzles, feeds, cuddles, envelops, caresses, lies next to, and hugs her baby. (p. 62)

Theraplay sessions are highly structured, directed by the therapist and focus on providing activities that mimic the ideal parenting activities as noted above. For example, a structuring activity may be building a tower of five pillows, walking with hats balanced on head, walking on the blue squares only or drawing around hands or bodies, thus clearly delineating time and space and teaching mastery through the internalization of rules. Challenging activities may include peek-a-boo, hide and seek, wrestling, tug of war, or pillow fights and thus provide the opportunity for children to experience themselves as separate. It also provides a safe, controlled environment which teaches children that competition and confrontation can relieve tension and pent-up anger. Intruding activities such as tickling and surprising children with the unexpected serve to teach them where they leave off and the rest of the world begins, again, enhancing their experience of being a separate individual being. Nurturing activities, which communicate to children feelings of self-worth may include tummy rubbing, singing lullabies, cuddling, rocking, applying lotion or bottle-feeding (pp. 46-47).

The theoretical tenets of Theraplay are based on Austin Des Lauriers' work with autistic and schizophrenic children in the 1960's. Like Des Lauriers, Jernberg (1979)

describes Theraplay as vigorous, therapeutically intrusive, utilizing body and eye contact, focusing on intimacy between child and therapist, emphasizing the present, and ignoring the bizarre, the past and fantasy (p. 2). However, Theraplay differs from Des Lauriers' approach in terms of the higher "degree to which the therapist initiates, structures, and takes charge of the session" (p. 2) and in its regressive dimensions (i.e., nurturing activities such as bottle-feeding) (p. 3). Furthermore, Jernberg (1979) maintains that Theraplay can be used with families, with individual adults (including parents of children in Theraplay), in groups, over the telephone (in crisis) and in the home.

Theraplay therapists see this method as effective in the treatment of many different emotional, social and developmental problems usually experienced by those who, "as a result of ... early deprivations, have low confidence in themselves and little trust in their worlds (Jernberg, 1979, p. 26). However, Theraplay is contraindicated or, minimally, should be modified, for children who have been recently traumatized (e.g., death of a parent, surgery), or if they have been physically or sexually abused (Jernberg, 1979, pp. 26-32). Jernberg and Booth (1999) elaborate on this in the second revised edition of the book.

Cognitive-Behavioural Play Therapy

Knell (1993) describes cognitive-behavioural play therapy (CBPT) as incorporating "cognitive and behavioural interventions within a play paradigm" (p. 43). Children are encouraged to be active participants in treatment designed to modify and/or change their behaviour and thought processes. CBPT focuses on children's thoughts, feelings, fantasies and environment in a structured, directive and goal-oriented course of treatment. Common techniques of CBPT include modelling positive self-statements

(often by puppets or dolls) and teaching life skills or alternative behaviours, for example, to help children prevent future maltreatment.

In contrast to non-directive models of play therapy, therapeutic goals in CBPT may be established either based on cues from the child or based on knowledge garnered from outside sources. The therapist may glean important information from a child's choice of toys and play behaviour in order then to structure play sessions specifically addressing the child's issues. Also in contrast to the non-directive models of play therapy, "praise is a critical component of CBPT because it helps children feel good about themselves ... and communicates to the child which behaviours are appropriate and which ones are not" (Knell, 1993, p. 50). Finally, unlike the role of non-directive play therapists, the role of the cognitive-behavioural play therapist is to interpret for children verbally the conflicts they demonstrate through play, thus increasing their level of understanding.

Thematic Play Therapy

Thematic Play Therapy (Benedict & Mongoven, 1997) tries to "undo" an attachment-disordered child's negative expectations of caregivers by providing the child with a consistent, positive, trustworthy and reliable relationship. Once such a relationship is established, the therapist attempts to respond to the child's play themes by elaborating and modifying her or his play metaphors with the purpose of helping the child to express feelings, heal from past traumas and develop a healthier relationship with her or his environment.

Ecosystemic Play Therapy

O'Connor and Ammen (1997) summarize ecosystemic play therapy as "an integrative theory incorporating developmental (individual and family), systemic (dyadic, familial, social and other systems), contextual (sociocultural metasystems), and representational (intrapsychic) variables from the perspective of the child's functioning in his or her ecosystemic world" (p. 13).

They describe the primary purpose of this play therapy model as resolving children's psychopathology, that is, "to enable children to get their needs met consistently and in ways that do not interfere with the ability of others to get their needs met" (O'Connor & Ammen, 1997, p. 11). A secondary purpose of this type of play therapy is to facilitate children's optimal development and functioning.

The authors view the child as the basic unit of this model operating in three domains: 1) the child as a physical body, 2) the child as part of her or his environment including her or his interpersonal relationships, and 3) the child as represented by her or his internal working models (O'Connor & Ammen, 1997, p. 7). In practice, play therapists using this model expose children to corrective experiences and behaviour at an interactional and experiential level as well as through the facilitation of cognitive and emotional understanding at an intrapsychic and representational level.

Play Therapy Techniques

There are a great variety of play therapy techniques including bibliotherapy (e.g., storybooks, structured workbooks), storytelling, art work (e.g., drawing, painting, clay, play-doh, finger painting), puppet and doll play, sand play, game play, music, role plays and techniques borrowed from the Theraplay modality of play therapy. These

activities can be enjoyable for children, and encourage relationship building and communication between clients and therapists. Furthermore, many of the techniques allow for a certain degree of distancing of the child from painful experiences allowing her or him to process them gradually in a less anxiety-ridden and more manageable manner. While often incorporated into other play therapy models, three of the most popular techniques – artwork, sand play and music – are also often treated as distinct from other play therapies in the literature. They are discussed in more detail below:

Artwork

Nickerson (1983) describes art as an ideal play therapeutic medium in that it "offers children an opportunity to communicate through the use of a variety of materials ... feelings and concerns that bother them but which they may not fully understand or be able to 'talk out' directly with a therapist" (p. 237). In this manner, art facilitates communication with children surmounting barriers such as language, culture, repressed experiences and resistance.

Depending on the theoretical orientation of the therapist, art activities such as painting, drawing, sculpting, using play-doh and making craft projects (e.g., beadwork, quilting, silk-screening, doll-making) can be used to facilitate the therapeutic process and goal attainment which usually includes catharsis, self-expression and a sense of mastery.

According to Brems (1993), art can be used for the assessment of children's functioning including their developmental level, their perceptions, needs, emotions and conflicts. Children's artwork can be interpreted by assessing the process of its creation, its form and its content. Process, according to Brems (1993), refers to children's attitudes towards what they are doing, for example, their degree of hesitancy, level of

enjoyment, spontaneity and inhibition. Assessing process can assist clinicians in the formation of hypotheses about children's defenses and coping mechanisms (Brems, 1993).

Form refers to the creation's overall presentation. For example, assessing the creation's degree of organization, colour, size and shape of objects used in comparison to one another may provide important information about children's developmental levels, feelings, perceptions and inner working models.

According to Brems (1993), the content of children's creations can be interpreted on three different levels. The first level refers to the interpretation of information about the actual creation. The second level refers to the associated content derived from the title of the creation or stories about it. The third level refers to the implied or latent content derived from the symbolism of the creation. The therapist's role in art therapy is to facilitate the process by observing and inquiring about the child's creation, assessing and making note of recurrent themes, and addressing those themes with the child (according to the theoretical base used) as a means of resolving conflicts and promoting optimal functioning.

Sand Play

Margaret Lowenfeld, working with children in the 1930's and onwards, is credited with innovative work in the field of play therapy. Rather than subscribing to any particular theoretical or medical model, she focused on the process of enabling children to discover the positive aspects of their own personalities through sand play. Calling it the "World Technique", Lowenfeld invited children to create their world in a sand tray using any materials they wanted. The child's world could be "the re-creation of an actual event

that has happened, the expression of a fantasy, repetition over and over again of an important scene, and scenes that make complete sense to the child but are not understandable, even with description, to the therapist" (cited in Jennings, 1993).

In the 1970's and 1980's, Dora Kalff, a Jungian analyst, appears to have been very much influenced by the work of Lowenfeld. Kalff (1980) endorses Jung's theory of the human individuation process viewing sand play as a particularly effective therapeutic process for assisting children in the development of a healthy ego. The development of a healthy ego, according to Kalff, is depicted in sand play in the following manner:

> ... In the first phase, the ego expresses itself chiefly in pictures in which animals and vegetation predominate. The next stage brings battles, which appear again and again, especially in puberty. By now, the child is so strengthened that he can take upon himself the battle with external influences and he can come to grips with them. Finally he is admitted to the environment as a person and becomes a member of the collective. (p. 33)

Music

According to the Canadian Association for Music Therapy (1992), the non-verbal, creative and affective nature of music facilitates contact, self-expression, communication and growth. Therapeutically, musical activities can facilitate many different tasks. Examples include:

- *Listening to Music* – develops cognitive skills such as attention and memory; facilitates the processing of difficult issues by providing a creative environment for

self-expression and evoking memories and association; stimulates thoughts, images and feelings which can be further examined with the therapist or other supportive person.

- *Composing* – facilitates the expression and understanding of feelings; provides opportunity for self-awareness and catharsis; encourages the sharing of feelings, ideas and experiences with others.
- *Improvising* – provides opportunity for assessment; encourages a creative way of making choices and dealing with structure.
- *Singing* – increases feelings of confidence; provides an opportunity for relaxation and enjoyment; helps foster a sense of others (by singing together).
- *Playing an instrument* – improves gross and fine motor coordination; develops a person's musical skills, self-reliance, self-esteem and self-discipline.
- *Rhythmic movement* – helps to increase a person's motivation, interest and enjoyment, and acts as a nonverbal persuasion to involve individuals socially.

Summary

There are a great variety of play therapy models and play therapy techniques. All of the play therapies emphasize the importance of a positive therapeutic relationship between the therapist and the child. As Knell (1993) writes:

> Good rapport and trust are critical elements in engaging the child in treatment. ... Play activities as a means of communicating between therapist and child are universal to play therapies. In establishing the therapeutic relationship and in

> interacting with the child via play, play therapists communicate to the child that therapy is a safe place. (p. 51)

Leve (1995) notes other common features of the various play therapies with children including 1) the facilitation of emotional release and expression of feelings, 2) the encouragement of cognitive and experiential learning either directly or indirectly with the purpose of teaching more adaptive ways of behaving or coping, and 3) the encouragement of generalizing these new behaviours and coping skills to the child's larger environment.

Play therapies differ in their degree of structure, the degree to which the therapist or child determines the focus and course of treatment, the degree to which other systems are involved in the process, the degree of emphasis on the importance of the child's environment, and the degree of emphasis on interpretation of the child's behaviour. Obviously, some therapies are more suited to particular types of children with particular presenting problems and some, such as Theraplay and filial therapy, are generally contraindicated or need modifications with others, such as children who have been abused. Schaefer and O'Connor (1983) suggest a prescriptive approach which "emphasizes the therapist's responsibility to determine the most appropriate therapeutic technique for each particular case" (p. 1).

Treatment Issues with Children who have been Abused or Neglected

Children's Victimization and Traumatization

Current literature encompassing clinically and empirically derived knowledge suggests that the victimization and traumatization of maltreated children can have both immediate and long-lasting effects (Briere, 1992; Gil, 1991; Hindman, 1989; James,

1994; Kendall-Tackett, Williams, & Finkelhor, 1993; Pearce & Pezzot-Pearce, 1997; Terr, 1991). While the terms are often used interchangeably, some clinicians and researchers differentiate between victimization and traumatization, noting that many victimized children are traumatized but not all experience their victimization as traumatic to the same degree. For example, Gil (1991) notes that "the same event, with subsequent similar responses, can be experienced differently by one child than by others when there has been no previous indication of marked personality differences among the children" (p. 39). She goes on to say that "only the children can tell or show us what meaning the experience has had to them" (Gil, 1991, p. 40).

Hindman (1989), in her discussion of factors increasing the likelihood of traumatization in children who have been sexually abused, cites the following nine factors as correlated to the degree of trauma experienced by the child victim: the responsiveness or perceived responsiveness of the victim's body to the abuse; the cultivation of terror in the victim by the offender; the relationship of the offender to the victim; the victim's belief that she or he can control the abuse by changing some aspect of her or his behaviour; the age of the victim; the development of amnesia or dissociation as coping skills in the aftermath of victimization; keeping the abuse a secret; a disastrous response to the abuse when it is discovered or disclosed (e.g., disbelief, blame, punishment); and the offender retaining a traumatic hold over the victim resulting in lack of resolution and clarification (pp. 78-88).

Kendall-Tackett et al. (1993) note that variables such as age of the child, severity and chronicity of the abuse, relationship to the offender, environmental factors, and personality and biological factors all affect the degree of impact of sexual abuse on

children. Additional factors include the child's cognitive abilities, cognitive interpretation of the abuse, coping skills and prior adjustment.

James (1994) notes that children's ability to cope with victimization is determined by "age, verbal abilities, strength, mobility, freedom, experience, and availability of attachment figures" (p. 11). She continues:

> Children's responses to trauma are complex and are different from those of adults because of the vulnerabilities and the needs of childhood. Children's traumatizing experiences, particularly when chronic, can compromise all areas of childhood development, including identity formation, cognitive processing, experience of body integrity, ability to manage behaviour, affect tolerance, spiritual and moral development, and ability to trust self and others. (pp. 10-11)

Terr (1991) perhaps encapsulates most succinctly with her taxonomy of Type I and Type II trauma the importance of context in the potential traumatization of children. Terr (1991) describes Type I trauma as occurring after an unexpected single event (e.g., natural disaster, traffic accident, death of a parent) experienced by a reasonably well-adjusted child in an otherwise reasonably stable environment. Type II trauma refers to trauma resulting from long-standing or repeated exposure to multiple traumas, for example, chronic child maltreatment and neglect. Symptomology generally includes: 1) strongly visualized or otherwise repeatedly perceived memories, 2) repetitive behaviours, 3) trauma specific fears and 4) changed attitudes about people, aspects of life, and the future (Terr, 1991).

The Impact of Maltreatment on Children

In her clinical work with maltreated children, Gil (1991) observes and categorizes both internalizing and externalizing behavioural symptoms of child maltreatment. She cautions, however, that these behaviours may not be definitive indicators of abuse as children who are not abused but, nevertheless, live in dysfunctional families or who have recently suffered some sort of crisis or loss, may also exhibit these behaviours.

According to Gil (1991), children with internalized behavioural indicators tend to be isolated, withdrawn, attempt to deal with their abuse on their own and frequently:

- appear withdrawn and unmotivated to seek interactions
- exhibit clinical signs of depression
- lack spontaneity and playfulness
- are overly compliant
- develop phobias with unspecified precipitants
- appear hyper-vigilant and anxious
- experience sleep disorders and night terrors
- demonstrate regressed behaviour
- have somatic complaints (e.g., stomach aches, headaches)
- develop eating disorders
- engage in substance and drug abuse
- make suicidal gestures
- engage in self-mutilation
- dissociate. (pp. 12-13)

Children exhibiting external behavioural indicators of abuse engage in behaviour directed towards others and may frequently appear:

- hostile, aggressive and destructive
- provocative (eliciting abuse)
- violent (sometimes torturing and killing animals)
- prone to destructive behaviours (e.g. fire-setting, vandalism)
- sexualized. (Gil, 1991, p. 13)

In general, James (1994) maintains that the symptoms of trauma in children fall into four major categories and range in their intensity from mild to severe:

- Persistent fear state
- Disorder of memory
- Dysregulation of affect
- Avoidance of intimacy.

Perry believes that a persistent fear state can result from stress of sufficient duration, intensity or frequency resulting in altered brain chemistry (cited in James, 1994, pp. 11-12). Examples of behaviours observed in traumatized children experiencing a persistent state of fear include hypervigilance, heightened startle response, increased irritability, anxiety, physical hyperactivity, and extreme regressive behaviours.

Disorder of memory refers to an inability to process and store the traumatic event or events in memory. Flashbacks, that is, sudden, spontaneous re-experiencing of all or part of a traumatizing event, and dissociation, a sudden, temporary disturbance in the normally integrative functions of identity, memory or consciousness, are common forms of memory disturbances. In children, especially, behaviors that sometimes indicate

trauma-related memory disorganization include lying, unexplained aggression, withdrawal, or weird or "spacey" behaviour.

Dysregulation of affect is commonly experienced by trauma survivors as they try to control or prevent recollections of the event through numbing and affect avoidance. According to James (1994), components of traumatized children's play (verbalizations, movement, and fantasy productions) are often severely restricted and interspersed with "out-of-control affective storms unrelated to play" (p. 14). Traumatized children may also experience alexithymia, a condition in which one is only aware of the physiological aspects of affect (e.g., increased heart rate, dry mouth) but cannot identify the accompanying emotion. Common behaviours in children with dysregulation of affect include oppositional, defiant, uncooperative, anxious, depressed, impulse-ridden, and unpredictable behaviour.

Finally, children who have been traumatized often avoid intimacy because of the perceived danger inherent in such relationships, which triggers feelings of vulnerability and loss of control. James (1994) points out that "intimacy avoidance is an adaptive response in children who have been hurt by adults or who have witnessed adult violence" (p. 15). Behaviour that serves to avoid intimacy includes clinginess, hyperactivity, avoidance of eye contact, withdrawal, oppositional behaviour and the development of off-putting personal habits (e.g., poor personal hygiene, deliberate soiling or wetting).

Specifically in terms of sexual abuse, Finkelhor (1986) outlines the dynamics, psychological impact and children's behavioural manifestations using a four-factor conceptual model: traumatic sexualization, stigmatization, powerlessness, and betrayal. Other research in this area (Friedrich, 1990, 1991; Gil & Johnson, 1993; Sgroi, 1982)

supports Finkelhor's conceptualization of the impact of sexual abuse on children and provides assessment tools for determining, usually on a continuum, developmentally appropriate sexual play versus disturbed sexual play in children.

Briere (1992) concludes that the impact of child abuse, regardless of the specific type, is likely to occur in at least three stages: 1) the initial reaction to victimization which involves post-traumatic stress, disturbances in normal childhood development, painful affect, and cognitive distortions; 2) accommodation to ongoing abuse which involves developing coping behaviours intended to increase safety and decrease pain during victimization; and 3) long-term elaboration and secondary accommodation which reflects the impact of earlier events on the individual's later psychological functioning and her or his ongoing coping responses to abuse-related dysphoria. He continues, "Although some of the initial reactions of victims to their abuse may abate with time, more typically such disturbances, along with abuse-specific coping behaviours, generalize and elaborate over the long term if untreated" (p. 18).

Pearce and Pezzot-Pearce (1997) offer a developmental model that includes a summary and integration of research findings to date on the sequelae of child maltreatment. The basic assumptions upon which their model is based include: 1) that abusive or neglectful parenting is determined by the interaction of many different variables including the psychological characteristics of the parents, the family setting and its dynamics, the immediate social network of the family members, the current state of society as it pertains to maltreatment, and the interaction of these variables; 2) that child maltreatment should be regarded as only one of several variables that may contribute to

specific developmental outcomes; and 3) that stage-salient development issues must be considered when assessing the impact on children of maltreatment (pp. 7-10).

Pearce and Pezzot-Pearce (1997) refer to stage-salient development issues as:

> the need of an individual to confront specific developmental tasks that are central to that age. ... Upon emergence, each remains critical to the child's continual adaptation, although decreasing in salience relative to newly emerging tasks. In optimal development, the child successfully negotiates the progression of stage-salient issues and moves through a course of increasing competence and adaptation. In other words, later competencies build upon earlier competencies. The maltreating environment may have a significant negative impact upon this progression, but numerous other factors can mediate its impact. (pp. 8-9)

Examples of stage-salient developmental tasks include the establishment of a secure attachment; emotional and behavioural self-regulation; development of an autonomous self; language development; development of symbolic play; adaptation to school; and establishing peer relationships. According to the research reviewed, maltreated children who are prevented from successfully negotiating these developmental tasks are at significant risk for the development of a number of problems including insecure attachments and a negative internal working model; poor emotional and behavioural self-regulatory skills resulting in aggression and sexualized behaviour; depression and anxiety; a compromised sense of self; lowered cognitive functioning;

deficiencies in language; and poor peer relationships (Pearce & Pezzot-Pearce, 1997, p. 39).

Pearce and Pezzot-Pearce (1997) note that "despite being at increased risk for psychological and behavioural problems, maltreated children do not demonstrate a uniform response or reaction to abuse or neglect. Furthermore, there is considerable overlap in the characteristics of children exposed to different subtypes of maltreatment, and some children subjected to abuse or neglect experience only transient effects whereas others display no symptoms" (p. 39).

Rationale for Use of Play Therapy with Children who have been Abused or Neglected

A multimodal approach including individual, dyadic, family and group therapy is recommended by many therapists for the treatment of abused and neglected children (O'Connor & Ammen, 1997; Steinhauer, 1991). Treatment of offending and non-offending parents is necessary to ensure the protection of the child and improve the parent-child relationship. Foster parents and other alternate caregivers require support and education in understanding the child's needs, thus preventing the perpetuation of destructive family dynamics (Delaney, 1991; Steinhauer, 1991).

Within a multimodal context, individual therapy with children to resolve issues of trauma, loss and neglectful parenting is often best accomplished using a play therapy approach, as play is the language of children and play therapy, an extension of the natural properties of play. Children who have been traumatized or neglected benefit from the safety, predictability, nurturing and basic limit setting provided by a non-judgmental play therapist. Mann and McDermott (1983) note:

> It (play therapy) has returned as a specific treatment of choice for certain conditions such as the effects of child abuse. It has been found useful, if not essential, to prevent crystallization and internalization of the effects of physical assault, rejection, and neglect, as well as distorted and disturbed parent-child interactions into the personality structure of the child. (p. 285)

Specifically regarding play therapy with children who have been abused, Cattanach (1992) proposes a multi-dimensional model based on four concepts:

> 1) the centrality of play as the child's way of understanding her world;
>
> 2) that play is a developmental process during which the child can move back and forth along a developmental continuum as a way of discovering individuation and separation;
>
> 3) that play is a symbolic process through which the child can explore experiences of abuse, safely distanced from the reality of her own life experiences; and
>
> 4) that play takes place in a "therapeutic space" representative of Winnicott's (1975) transitional space, that is, the relationship between mother and child which allows for individuation and separation of the child from the mother. The child, then, in therapy, is able to move back and forth along the developmental continuum and develop a relationship with the therapist who will

> hopefully allow her to meet and separate from a caring adult without the burden of an abuser/victim relationship. (pp. 41-46)

Johnson (1989) notes that toys for play therapy with a child traumatized by abuse or neglect need to encourage communication and can be used in numerous ways sometimes by eliciting aggressive responses from the child. As the child in therapy "plays with the toys in his or her own way, the therapist can respond to the feelings expressed, build an interactive relationship with the child, and gradually help the child understand and restructure behaviors around a particular problem" (p. 106). Additionally, play "can be structured by the therapist into a set of sequences encouraging the child to face and master areas of conflict in real life" (Johnson, 1989, p. 106).

Most importantly, Johnson (1989) describes the need for therapists working with abused and neglected children to not only build rapport with clients but to maintain it by encouraging verbal elaboration and by following the children's cues. The building of rapport with clients who have been victimized is well documented in the literature as trust and control issues are, understandably, so prevalent among this population (Briere, 1992; Cattanach, 1992; Delaney, 1991; Gardner, 1993; Gil, 1991; Hindman, 1992; James, 1994; Johnson, 1989; Landreth, Homeyer, Glover & Sweeney, 1996).

Treatment Issues with Children in Care

Common reasons for referral of maltreated children to play therapy include concerns about a child's behaviour (e.g., sexual acting out, aggressiveness, poor social skills); a child's emotional state (e.g., depression, anxiety, fearfulness); or simply the known victimization of a child or other family member. However, some children may

initially be unable to address these issues due to their need first to process issues of separation, loss and adjustment to an out-of-home placement.

Early studies of children separated from their parents concluded that 1) dramatic responses to separation appear to be universal among children, 2) children's responses to separation from parents appear to progress through a phase of protestation, despair and disorganization, and finally, detachment, and 3) certain conditions, such as adequate preparation, the presence of familiar alternative caregivers, and visits by the parents, alter the intensity and duration of children's responses (Bowlby, 1982; Heinicke & Westheimer, 1965; Robertson, 1953).

Unfortunately, children in foster care are likely to have been removed from home environments characterized by difficult and conflicted family relationships and, consequently, already experience deficits in their attachment capacity. Carlson, Cicchetti, Barnett, and Braunwald (1989) reported that a significant majority of infants maltreated by their parents were best categorized in a fourth and separate category not included in Ainsworth, Blehar, Waters and Wall's (1978) "Strange Situation" attachment research. Children in this fourth category – Disorganized/Disoriented – typically demonstrated behaviour that seemed to lack any obvious goal or intention. Additionally, one or more of the following behaviours was observed: "expected temporal sequences were frequently disorganized; they showed simultaneously contradictory behaviour patterns; their movements or expressions were often incomplete or lacking in direction, and at times included stereotypes; direct signs of confusion or apprehension of the parent were common, as were behavioural stilling or freezing" (cited in Steinhauer, 1991, p. 23).

Neglect, violence and abuse "all represent fundamentally unacceptable and, for the child, incomprehensible violations of the attachment system, with its inherent expectations of protection, safety, and security" (Adam, Keller, & West, 1995, p. 337). Steinhauer (1991) notes that "the more distressed the parent-child relationship – that is, the more insecure the attachment – the more intensely the child is likely to resist a separation, and the harder it will be for that child to mourn successfully (p. 27).

The importance of successful mourning is underscored by the literature, which suggests that children who are unable to mourn their loss adequately and/or to re-attach to alternative caregivers are at risk for developing serious and long-term sequelae. According to Steinhauer (1991), these include permanent detachment; persistent, diffuse rage; chronic depression; asocial and antisocial behaviour including lack of empathy, defects in conscience and defects in impulse control; low self-concept; and chronic dependency (pp. 32-37).

The role of the play therapist in assisting children with issues of temporary or permanent loss and adjustment to out-of-home placements will depend on each child's individual circumstances. If the child's out-of-home placement is temporary or if guardianship is undecided, the play therapist, as part of the child welfare team involved with the child, should work to protect, and improve the quality of, the attachment of the child to her or his birth parents. Therapeutic work, then, focuses on "supporting children to work through the intense feelings mobilized by separation" (Steinhauer, 1991, p. 157) by validating and normalizing those feelings (e.g., anxiety, sadness, loneliness, confusion, anger, hopefulness); talking to them about their parents and about home visits, and assisting them to connect current exaggerated, understated, or displaced emotions to

their original source (Steinhauer, 1991, p. 151); involving the birth parents and foster parents in the play therapy process as appropriate; and advocating for adequate visitation if necessary with the child welfare agency.

Additionally, play therapists can provide guidance to birth parents and foster parents in helping minimize the confusion and divided loyalties often experienced by children in out-of-home placements. It is not uncommon for foster parents and birth parents to compete for a child's affection and loyalty. Birth parents

> typically feel inadequate, powerless, and stigmatized by society's taking away their child. Often, they defend against their guilt and their sense of failure by projecting the blame onto someone else, such as the child, the foster parents, the child-welfare agency, or the courts. (Steinhauer, 1991, p. 161)

Foster parents are often critical and judgmental of birth parents because of how they have treated the child in the past. It is also not uncommon for foster parents to be motivated to foster by a need for love and appreciation. Children in foster care, however, frequently have a significant need for love and attention without the capacity to feel or give love in return. Steinhauer (1991) notes:

> It is easy to see why foster parents, who, day after day, week after week, have to put up with frustrating and disruptive behaviour while doing their best for a difficult child, might resent that child's seeming to care more for the idealized natural parents than for them. (p. 160)

The role of the play therapist with children in permanent out-of-home placements does not differ significantly from that with children in temporary care as it, too, will involve "supporting children to work through the intense feelings mobilized by separation" (Steinhauer, 1991, p. 157). However, it may also include advocating when appropriate for continued contact with birth parents; providing guidance to birth parents and foster parents for shared parenting in these instances; and providing guidance to foster parents for assisting children in the process of mourning in instances when contact is not maintained between birth parents and children.

Steinhauer (1991) suggests that professionals "can help most by sensitizing and empowering the foster mother and family" (p. 157) to facilitate successful mourning, noting that:

> ... since it is especially hard for many highly defended foster children to concentrate their mourning into the one or two hours each week that they meet their therapists ... the foster mother, given proper expectations, supervision, and support, is best able to provide the ongoing assistance most children need. (p. 147)

Specific points for intervention include:

- Having the foster parent note any changes in mood, activity level, expression, behaviour, fantasy, or play, or any marked withdrawal or increased aggression shortly before or just after visits or their cancellations, and using the opportunity to facilitate the working through of repressed feelings stirred up by an actual or frustrated contact with the natural parents (Steinhauer, p. 148).

- Assisting the foster parent to identify what Delaney (1991) refers to as many foster children's "negative world view" – that is, their responses to present circumstances with attitudes, motives and feelings based on past experiences and memories of their past environments and birth parents.
- Encouraging the foster parent to observe children's stories, play, drawings, dreams, and fantasies (e.g., abandonment, fear, deprivation, punishment), recognizing when themes emerge of previously experienced feelings and situations, and helping children explore these themes.
- Encouraging the foster parent to role model consistently kindness, sensitivity, caring and respect in the home, especially when responding to difficult behaviour of children originating in feelings derived from the past.

In summary, it is apparent that working with children in care can in some ways be a more complex process than working with children who remain at home. This is because, in addition to addressing family of origin issues which likely precipitated the out-of-home placement in the first place, issues of grief and loss, separation, potential idealization of the birth parents, adjustment to the new home environment, foster family dynamics and foster family attitudes towards the foster children and their birth parents also need to be addressed. Frequently, it has been my experience that these issues arising from the out-of-home placement need to be addressed before family of origin issues can become a focus of therapeutic work with the child.

THE LOGISTICS OF THE PRACTICUM

The Child Clients

Play therapy for this practicum was undertaken with four children all of whom were referred by the Children's Hospital Child Protection Centre (CPC) due to post-traumatic sequelae stemming from abuse or neglect.

A psychologist at Child Protection Centre referred five-year-old Annie for play therapy because of concerns about her emotional functioning. Concerns included social difficulties; a troubling preoccupation with themes of violence, injury and sexualized relationships; and conflict and confusion around intimate relationships. Annie's history included physical, emotional and sexual abuse; neglect; and exposure to adult domestic violence, substance abuse and sexual activity. At the time Annie started play therapy, she had been in foster care for approximately one year. Play therapy with Annie continued after the completion of this practicum. At the time of completion, she had participated in 49 play therapy sessions over a period of 14 months.

The CPC psychologist also referred six-year-old Curtis due to concerns about his difficulties with interpersonal relationships; poor self-esteem; and reported aggressive behaviour. Curtis' history included emotional and physical abuse, neglect, and parental abandonment. At the time Curtis started play therapy, he had been in care for approximately 18 months. Curtis had spent the majority of his time in care in a hotel with rotating childcare workers as his caregivers. He was moved to a specialized foster home two months prior to starting play therapy. Play therapy with Curtis continued after the completion of this practicum. At the time of completion, Curtis had participated in 51 play therapy sessions over a period of 14 months.

Four-year-old Lenny was referred through the Child Protection Centre's Child Development Clinic (CDC) due to concerns voiced by his guardian about his aggressive behaviour. Lenny's history included neglect, exposure to adult violence and substance abuse, and parental abandonment. A developmental assessment of him undertaken by CDC noted him to fall within the normal range of development with some delays in expressive speech. At the time Lenny started play therapy, he had been living with his caregiver, his maternal aunt, for approximately one and one-half years. Prior to that time, he was briefly placed in a Child and Family Services shelter subsequent to his apprehension from his mother's care. Lenny participated in 32 play therapy sessions over a period of ten months.

Ten-year-old Tracey, who turned 11 the day after her first play therapy session, was referred for play therapy through Child Protection Centre at the same time that her mother was referred for a parent-child assessment. Tracey's history included neglect, exposure to adult substance abuse and violence, and suspected victimization. Her guardianship agency expressed concern about an incident in which Tracey had attacked her mother with a knife. At the time Tracey started play therapy, she had been in the same foster home for approximately one and one-half years. Prior to that time, she had been primarily raised by her maternal grandparents with intermittent time spent in the care of her mother. Play therapy with Tracey continued after the completion of this practicum. At the time of completion, Tracey had participated in 37 play therapy sessions over a period of ten months.

The Setting

Play therapy with Annie, Curtis, Lenny and Tracey took place at the Elizabeth Hill Counselling Centre, part of the Faculty of Social Work at the University of Manitoba, and a training facility for social work and psychology students. Ms. Linda Perry and Dr. Diane Hiebert-Murphy, university faculty members, provided weekly supervision.

The Intervention

Assessment

Two of the four children participating in this play therapy practicum, Annie and Curtis, were referred for treatment after having been psychologically assessed. The referring psychologist made treatment recommendations that, along with information gathered from initial play sessions, collateral sources and reports on psychometric testing, became the foundation for play therapy goals with these children.

The other two children, Lenny and Tracy, were referred for play therapy without prior formal assessment. Because of this, initial play therapy sessions along with information gathered from collateral sources and reports on psychometric testing, were used to generate goals for a course of treatment. Assessment was guided by principles derived from a number of sources including Greenspan and Greenspan (1991) and O'Connor and Ammen (1997).

Greenspan and Greenspan (1991) outline a framework for the evaluation of the child, which includes physical functioning, pattern of relationships, overall mood or emotional tone, affect, anxieties and fears, and thematic expression (pp. 19 – 59).

O'Connor and Ammen (1997) offer comprehensive guidelines to the evaluation of the child in a systemic context (pp. 29 – 104).

In addition to assessment, initial play therapy sessions focused on relationship building, observation of the child's themes in play and taking my cues from the child for the most part. As a result, early play sessions were primarily non-directive and only minimally structured. This changed in later sessions after a relationship with the child had begun to develop. At that point, I attempted to direct activities and structure sessions more when addressing issues specific to the child. As part of my learning, I soon discovered that providing more direction and structure to the sessions from the beginning of therapy would probably have been more productive than trying to introduce it later in the therapeutic process. This became particularly apparent when trying to introduce activities to children with high control needs (e.g., Lenny, Annie and Curtis) after not having set a precedence of directing or structuring activities in previous sessions. The children proved to be resistant to my initiatives for the most part.

Treatment Process

In terms of the treatment process, a prescriptive approach was used based on my belief that the methodology from differing combinations of the play therapies would be beneficial for treatment with different children according to their individualized needs and temperaments (Schaefer & O'Connor, 1983). As part of the learning process, I also wanted to "try on" different play therapy approaches and techniques to expand my skill and knowledge base. While I attempted to use an ecosystemic framework with all of the children, with four-year-old Lenny, I employed a predominantly non-directive, child-focused approach using, at times, Theraplay techniques (to encourage attachment

behaviour) and ideas from the cognitive-behavioural play therapies (to address maladaptive coping behaviour) and the release play therapies (to provide opportunity for catharsis and abreaction). Work with Lenny's caregiver was also an important component of the treatment process.

With six-year-old Annie, who presented with behaviour consistent with an aggressive attachment disorder (Zeanah, Mammen, & Lieberman, 1993), I used a Thematic Play Therapy approach as prescribed by Benedict and Mongoven (1997). Advocacy with Annie's guardianship agency was also an important part of the treatment process.

I initially planned to use a predominantly Thematic Play Therapy approach with Curtis to encourage the development of a positive therapeutic relationship and to assist him in the grieving process for his mother who had stopped visiting him and planned to relinquish guardianship. However, when his mother recommenced visits and initiated a court process to regain guardianship of him, Curtis' highly defended manner of relating compromised his ability to process on a feelings level his present circumstances. As a result, a cognitive-behavioural approach was introduced to the play therapy sessions in an attempt to modify some of Curtis' self-blaming beliefs and aggressive behaviour.

Cognitive-behavioural play therapy was the primary approach used with ten-year-old Tracy. This approach was chosen due to Tracey's highly defended manner of relating and avoidant manner of dealing with strong, negative emotions such as anger, fear and loss.

At all times throughout the treatment process with all of the children, I attempted to set minimal limits for each child (e.g., the child was not allowed to hurt her/himself or

me). Additionally, in keeping with an ecosystemic framework, attempts were made to include all of the children's caregivers in the treatment process by scheduling meetings, keeping in contact by telephone, providing feedback and providing guidance and direction as needed.

Method of Evaluation

In terms of evaluating the effectiveness of this intervention with clients, I planned to administer Achenbach's Child Behaviour Checklist and the Parenting Stress Index to the children's caregivers in order to assess the children's pre- and post-intervention functioning. Because I had terminated with only one client (Lenny) at the time of writing, post-intervention measures to date have only been completed for him. A mid-point evaluation of Annie, Curtis and Tracey's functioning was undertaken with their caregivers. Annie's mid-point evaluation is included in this report as part of her case study. Post-intervention measures will be taken at termination with the remaining three clients.

Child Behaviour Checklist (CBCL)

The Child Behaviour Checklist (CBCL) was designed by Thomas Achenbach and Craig Edelbrock to assess in a standardized format the behavioural problems and social competencies of children between the ages of four and sixteen years (Achenbach & Edelbrock, 1983).

It consists of 118 items related to behaviour problems of the child, which are scored on a three-point scale ranging from "Not true" to "Often true". Additionally, there are twenty social competency items used to obtain parents' reports of the amount and quality of their child's activities, social interactions, and school functioning. Both

parts of the scale were normed on a sample of parents' reports on 13,000 children. Clinical and normative samples were heterogeneous in terms of race and socioeconomic status, and were proportionate to the composition of the general United States population (Achenbach & Edelbrock, 1983).

The main disadvantage of the CBCL is its reliance on parental report and the attending limitations (Freeman, 1985). Achenbach and Edelbrock have attempted to address this by providing other forms to generate data from other sources including The Teacher Rating Form (TRF), the Youth Self-Report (YSR) and the Direct Observation Form (DOF). It should be noted that the Youth Self-Report cannot be used by children under the age of eleven.

The psychometric properties of the CBCL's parent reports have been extensively evaluated. Test-retest reliability, inter-parent agreement, and inter-interviewer reliability coefficients have all been measured as greater than .90 (Kelley, 1985). Several studies of the CBCL have supported both its construct and criterion-related validity (Kelley, 1985). While the supplementary measures have not been studied as thoroughly in terms of their psychometric properties, Christenson (1992) describes them as "well-designed and researched instruments to provide standardized descriptions of students' problems and competencies in the social-emotional area" (p. 166).

Parenting Stress Index (PSI)

The Parenting Stress Index (Third Edition) (PSI) was developed by Richard Abidin as a means of identifying stressors experienced by parents of children under the age of 12 that are related to dysfunctional parenting (Abidin, 1995).

Caregivers complete the PSI by circling a number using a five-point Likert scale that best reflects their perceptions of the child (Child Domain) and themselves (Parent Domain). The Child Domain consists of six subscales related to the temperament of the child (Adaptability, Demandingness, Mood and Distractibility/Hyperactivity); the match between child characteristics and parental expectations (Acceptability); and the extent to which the parent experiences the child as a positive reinforcement (Reinforces Parent). The seven subscales of the Parent Domain measure Depression, Feelings of Competence, Attachment, Support of Spouse, Health, Role Restriction and isolation. The remaining items on the PSI are contained in a Life Stress scale which offers an index of how much stress parents may be experiencing beyond their role as caregivers (Abidin, 1995).

The scale was normed on a sample of 2,633 mothers recruited from a well-child care centre, public school day care centres, private and public pediatric clinics, and health maintenance programs in the United States (Abidin, 1995). Allison (1998) points out that the PSI's standardization and resulting normative data is perhaps its biggest weakness as the sample was neither random nor stratified. Additionally, Barnes and Oehler-Stinnett (1998) note that "the only normative data available for father respondents are based on the responses of 200 fathers" (p. 724).

According to Allison (1998), the PSI has strong validity with scores demonstrating a relationship to children's development, behavioural problems, parent characteristics, family transition issues, and marital relationships. Additionally, she notes, "95% of the original PSI's items were directly related to at least one research study that provided evidence for the importance of the attribute measured by the item to parental stress" (p. 723). She described the scale as a useful screening tool within a systems

context for identifying children who may be at-risk for emotional or behavioural problems, as well as parents who may be in need of parent education or professional assistance.

In terms of reliability, internal consistency data for the PSI is also strong. The reliability for each of the domains yields scores of .90 for the Child Domain, .93 for the Parent Domain, and .95 for the Total Scale (Allison, 1998). Scores are generally lower, but still acceptable for the subscales within the two domains ranging from .70 to .84 (Allison, 1998). Test-retest reliabilities on the Total Stress score range from .65 (one-year interval) to .96 for an interval of one to three months (Allison, 1998). According to Allison (1998), "these data are consistent with expected patterns reflecting the situational nature of parental stress" (p. 723).

Allison (1998) describes the PSI as a "valuable tool" (p. 722) for both researchers and clinicians as long as its limitations in terms of its normative data are noted. In contrast, Barnes and Oehler-Stinnett (1998), who question the internal structure and meaning of the Index's subscales, suggest greater caution in interpreting scores and predicting adjustment and behaviour in parents and children. They conclude that the use of the PSI be limited to screening and interviewing purposes for follow up on specific difficulties experienced by parents and children.

Customer Satisfaction Questionnaires

A customer satisfaction questionnaire (see Appendix) was completed by only one of the caregivers of a child who participated in this practicum experience as play therapy with the other three clients continued after its completion. Caregivers for the remaining children will be asked to complete a customer satisfaction questionnaire when therapy is

terminated. The purpose of this measure is to discover caregivers' perception of the treatment process.

CASE STUDIES

The following two case studies will be used to illustrate the practicum process. Case studies include a description of the reason for referral, background information, initial assessment, goal setting, therapeutic interventions and outcomes, and evaluation. All names and identifying information have been changed to protect confidentiality.

Lenny

Background Information

Lenny was referred for play therapy due to his maternal aunt's concerns about his aggressive behaviour. According to information provided by Lenny's aunt and Child and Family Services, Lenny and his younger sister, Christine, were apprehended from their parents' care due to concerns about domestic violence; parental drug abuse; ongoing neglect of both children (e.g., leaving the children unattended, frequently leaving them with inappropriate babysitters, leaving them in their cribs all day, not providing adequate stimulation); and suspected physical abuse. The children were apprehended after agency in-home supports failed to improve the parents' ability to meet their needs or to reduce the children's risk of abuse and neglect.

The children were placed in an agency emergency shelter for several months before the courts granted guardianship to their maternal aunt. The maternal aunt is a single woman living on her own and supported by social assistance. Lenny was almost three years old at this time, his sister a year younger. Lenny, who was attending daycare prior to his apprehension, was able to continue attending the same daycare after he went

to live with his aunt. The children's' parents were allowed to visit them in their new home and currently continue to have sporadic contact with them.

Initial Assessment

Information about Lenny's functioning was gathered from several sources at the beginning of the play therapy process. Collateral sources included the referring doctor from Child Protection Centre, Child and Family Services, the daycare that Lenny attended, and Lenny's aunt.

Information Provided by the Referring Doctor

The referring doctor described Lenny as falling within a normal range of development with some delays in expressive speech. He attributed descriptions of Lenny's aggressive and difficult to manage behaviour to Lenny missing his parents who frequently promised to visit and then did not show up. He also attributed Lenny's aggressive behaviour to him having difficulty expressing his feelings verbally, experiencing role confusion about his various caregivers, witnessing arguments between his current caregiver and his parents, and having general difficulties adjusting to his new home environment.

Information Provided by Child and Family Services

Child and Family Services expressed concern about short- and long-term effects of the neglect previously experienced by Lenny in his family of origin with two low functioning parents. Other concerns included his current caregiver's difficulties in managing Lenny's behaviour, her limited knowledge of normal childhood development and setting limits around contact between Lenny and his parents.

Information Provided by Daycare Personnel

Daycare personnel described Lenny as a sociable child who smiled frequently and often seemed happy. They did not view him as a difficult or aggressive child. They noted no developmental concerns other than some delays in expressive speech and a tendency at times towards parallel rather than interactive play with other children. His interaction with both children and adults was otherwise described as positive with an ability to show caring for their feelings.

In terms of Lenny's relationship with his aunt, daycare personnel described some anxiety around separating from her when she brought him in every morning. At the end of the day, Lenny appeared to greet her enthusiastically. According to daycare personnel, Lenny did not talk about any concerning issues from his previous home environment (e.g., violence, drug use) or his current home environment. Occasional descriptive comments about his parents' absence were stated with a noticeable lack of affect.

Information Provided by Lenny's Aunt

Lenny's aunt spoke in a frustrated, exasperated and worried manner about her nephew as well as about his parents. She reported many concerns about Lenny's aggression, especially towards his younger sister. She also stated that she was concerned about his "hyperactivity", destructiveness towards possessions, not taking responsibility when he was caught misbehaving, not listening (especially when out in public), lying, and not feeling any remorse when he hurt others. She attributed Lenny's behavioural difficulties to his anger towards, and sadness about, his parents' absence in his life. In speaking about Lenny's parents, Lenny's aunt expressed a fair amount of anger and

frustration about the home environment they provided for their children previously and what she saw as their lack of responsibility in caring for them currently.

The items endorsed by Lenny's aunt on the Child Behaviour Checklist produced scores within a clinical range in reference to both Lenny's Internalizing and Externalizing behaviours. Her responses on the Parenting Stress Index indicated that she experienced high levels of stress (within the clinical range) in parenting Lenny exacerbated by factors related to herself, to the child, and to their interaction. Results of the measures for Lenny will be discussed in further detail under the heading Evaluation.

Observations of Lenny in the Playroom

During our first time together in the playroom, Lenny presented as shy and anxious. As a result, I invited his aunt into the playroom with us. Lenny initially stayed close to his aunt without speaking. When asked if he wanted some juice and cookies, he shook his head. After being given permission to play with whatever he wanted to, Lenny slowly began to explore the playroom, remaining close to his aunt and not speaking. He eventually chose a beach ball and silently began to kick and throw it back and forth to both his aunt and me, displaying excellent coordination.

When I talked about the reasons for his aunt bringing him to play therapy (e.g., how he used to live with his parents and now lived with his aunt), Lenny nodded in agreement but did not speak or make eye contact. When I asked how old he had been on his recent birthday, he stated "four" very clearly but again without making eye contact.

Lenny initially expressed concern when his aunt went to leave the room to fill out the psychometric measures and attempted to follow her. After being shown where she would be, Lenny was able to remain in the playroom and continue playing. He checked

on her several times but easily returned to the playroom each time. At the end of the session, Lenny ran out of the playroom and ran around the office hallways, giggling and smiling. Lenny's aunt expressed exhaustion and frustration, and appeared to have difficulty controlling this behaviour or setting limits with him. Lenny accepted some juice and cookies to take with him when he left.

During the next few sessions, Lenny dashed to the playroom as soon as he arrived at the Counselling Centre. He generally delayed leaving at the end of sessions by dawdling, continuing to play, hiding or by running about the hallways giggling, smiling, avoiding his aunt's and my attempts to catch him, and shouting, "Look at me!" and "Try and catch me!" When in the playroom, he would sometimes suddenly attempt to leave the room without warning or with a brief comment about going to see his aunt. During some sessions, he did not leave the playroom at all, while during other sessions, he would leave the playroom four or five times to see his aunt.

When exploring the playroom, Lenny rarely spoke, did not make eye contact and frequently kept his back to me. He often chose to play on the other side of the room from where I was sitting. At times, he answered my questions with single words or brief sentences. At other times, he did not answer at all. He engaged me in throwing and kicking balls back and forth for part of the initial sessions. In later sessions, he also, at times, liked to have me watch him throw and kick various balls, and shoot miniature toy arrows in the air with a toy bow.

His predominant affect in the initial sessions included anxiety and worry around issues of separation with a façade, however, of playful manipulativeness around the issue of control (Greenspan & Greenspan, 1991). His manner of relating, even when smiling

and giggling lacked affective depth (i.e., did not smile with his eyes, hollow giggling without sounding happy) and was characterized by controlling behaviour and the use of distancing (e.g., running away, teasing, avoiding eye contact, not listening, hiding, turning his back towards his caregiver, pulling away from attempts to hold his hand).

Lenny did not develop cohesive themes in his play, but tended, instead, to move frequently from one activity to another in quick succession. He was able to demonstrate some of his conflicts through play, however, as well as limited verbal expression. Themes that emerged during Lenny's early play therapy sessions and developed throughout the course of play therapy included 1) violence and aggression, 2) power/control vs powerlessness/helplessness, 3) sadness and anger in relationship to loss, abandonment and general family dynamics, and 4) need for nurturance.

In summary, Lenny presented as an anxious, worried and somewhat sad little boy in the context of separation and abandonment issues, with a superficial playfulness about him masking issues around power and control. He related to his aunt and to me in a detached, controlling manner. While he demonstrated excellent gross motor coordination, he displayed delays in his expressive speech. Information from collateral sources suggested that Lenny's current caregiver was having difficulty managing his everyday behaviour and addressing his emotional needs.

Goal Setting

Based on information gathered from collateral sources and my initial assessment of Lenny during early play therapy sessions, the following goals for treatment were generated:

1) **Develop a relationship with Lenny that is based on trust.** The purpose of this goal was to decrease Lenny's anxiety in order to facilitate the other treatment goals.

2) **Assist Lenny to explore some of the events in his past and present home environment through observation and interpretation of prevalent play themes.** The purpose of this goal was to provide Lenny with the opportunity for cathartic play and abreaction regarding traumatic events in his life. Catharsis refers to the "arousal and discharge of strong emotions (positive and negative) for therapeutic relief" (Schaefer, 1993, p. 8). Abreaction is a more intense process than catharsis with the discharge of affect being greater. It refers to the reliving of past stressful events and the emotions association with them. In so doing, children will hopefully experience a sense of relief from tension, develop a better understanding of themselves and their environments, "gain mastery over a world that they tend to experience passively in real life" (Schaefer, 1993, p. 8) and be able to proceed on a healthy course of development. Observation of play themes also offers an opportunity for ongoing assessment of the child as treatment unfolds.

3) **Assist Lenny to develop a "feelings" vocabulary to enable him to express himself better.** The purpose of this goal was to foster Lenny's healthy growth and development and to increase his ability to communicate his feelings to others thus decreasing any aggressive behaviour due to difficulties in verbalizing his feelings.

4) **Assist Lenny to process his negative and overpowering feelings regarding the separation from his parents, that is, assist him in the mourning process.** The purpose of this goal was to assist Lenny to grieve about his separation from his parents and attach to his new caregiver successfully. As Steinhauer (1991) notes, "failure to complete the work of mourning" combined with "the lack of a satisfactory selective attachment prior to the separation, especially following chronic neglect" (p. 32) can result in children relating to their environment in a permanently detached manner. The consequences of this have been discussed previously.

5) **Encourage the normal development of empathy for others' feelings by verbalizing and demonstrating emotions in response to actions within an environment of tolerance and acceptance.** The purpose of this goal was to promote Lenny's healthy development and a healthy attachment capacity to others. It was included as a goal due the maternal aunt's concerns regarding Lenny's lack of empathy.

6) **Encourage Lenny with mastery of age-appropriate tasks.** The purpose of this goal was to promote healthy development and to strengthen Lenny's self-esteem by providing encouragement and opportunity for repeated successes.

7) **Educate Lenny's aunt about normal childhood development and individual children's temperaments.** The purpose of this goal was to assist Lenny's caregiver differentiate between behaviour in her nephew that warranted concern and behaviour that was developmentally appropriate. Another purpose was to help her identify strengths in Lenny that would

hopefully allow her to develop a more positive interpretation of some of his behaviour.

8) **Assist Lenny's aunt to develop parenting skills such as setting limits, responding to behavioural cues, and dealing with sibling rivalry.** The purpose of this goal was to help Lenny's aunt respond more appropriately to her nephew's behaviour and provide him and his younger sister with a less stressful, more consistent environment.

9) **Assist Lenny's aunt to become more comfortable and confident in her new role as a parent to her nephew and niece.** The purpose of this goal was to enhance the caregiver-child relationship by promoting attachment behaviour in both Lenny and his aunt (Delaney, 1991; Jernberg, 1979; Jernberg & Booth, 1997).

Therapeutic Interventions and Outcomes

The following is a synopsis of the therapeutic interventions and outcomes with Lenny:

1) Develop a relationship with Lenny based on trust.

In attempting to develop a trusting relationship with Lenny, I was challenged by his anxiety, and his detached and controlling manner of relating. By inviting his aunt into the playroom initially and allowing Lenny to check on her whereabouts at any time during subsequent play sessions, I hoped to relieve some of his separation anxiety.

I also made every effort to take my cues from Lenny about physical proximity and interaction. For example, when singing "Twinkle, Twinkle Little Star", I stopped singing when he told me to and listened to him sing the song with his back turned to me. When

blowing up balloons together, I stopped letting the air out of them noisily when Lenny indicated this hurt his ears. On several occasions when he asked me to pick him up, I did so and put him down again quickly as instructed.

Interestingly, this approach with Lenny, which I thought was respectful and which felt comfortable to me, only seemed to reinforce his detached way of relating to me. I eventually discovered that a more intrusive manner using Theraplay techniques (Jernberg, 1979; Jernberg & Booth, 1999) produced a richer level of relating to one another. For example, on one occasion, Lenny pretended to be injured. As he lay on the floor, I gently rubbed and smoothed his various body parts (e.g., feet, legs, hands, arms, face, head and eventually his back) describing what I was doing to make him feel better. Lenny, usually active and bouncing between activities, allowed me to continue with this activity for an extended period of time. He made prolonged eye contact with me, smiled and then asked me to continue rubbing his back.

During a subsequent session, I found Lenny curled up in the corner of the playroom pretending to be asleep under a pile of blankets after having raced around the hallways. When I commented that he looked like a little baby and started to sing him a lullaby, Lenny snuggled up to me and began to make gurgling noises like a baby. He later sat on my lap on several occasions while he drank his juice from a bottle.

Greenspan and Greenspan (1991) suggest that therapists make note of their subjective experience of a child as a means of gaining additional insight into the child's functioning. This was certainly beneficial with Lenny in terms of assessing his detached way of relating to others. Throughout my time with Lenny, in many ways a delightful child, I never felt as connected to him as I did with some of the other children that I saw

for play therapy. Despite some warm shared moments, he always seemed distant from me and emotionally uninvolved. While he usually rushed to the playroom at the beginning of sessions and made valiant efforts not to leave at the end of sessions, I rarely sensed a deepening of our relationship.

When his aunt reported that Lenny missed me when sessions were cancelled or talked excitedly about seeing me on the walk to the office, I was surprised. I was also taken by surprise on several different occasions when Lenny hugged me spontaneously, blew me kisses and told me he loved me. On these occasions, I found myself flooded with affection for him and puzzled by the dynamics of our relationship.

At the end of the session in which I rubbed Lenny's back, Lenny asked to be carried out to the waiting area. This became part of our routine at the end of all of our subsequent sessions. He liked me to carry him facing outward and to swing his legs. When it was time to say good-bye at the end of our last session, perhaps as a metaphor of our deepening yet still relatively detached relationship, Lenny had me carry him out of the playroom face to face as he clutched his arms around my neck.

2) Assist Lenny to explore some of the events in his past and present home environment through observation of prevalent play themes.

The primary intervention technique used with Lenny to help him explore events in his past and present home environments was the provision of toys that would encourage play around these issues (e.g., a dollhouse, dolls to represent family members, a jail). Because of his young age and continued delay in expressive speech, extensive verbal processing of life events and related emotions was not possible. Instead, Lenny's

processing was observed through his play. Lenny's play themes were often inter-related and evolved in the following manner:

- ***Violence and aggression.*** Initially, Lenny frequently enacted scenes of car crashes; handcuffing "bad guys" and taking them to jail for stealing and fighting; people being injured and bleeding from falls and assaults, and needing medical attention; spanking stuffed animals for toileting accidents and aggressive behaviour; and pretending to hurt me, dolls and stuffed animals by pretending to shoot arrows at us and put pepper in our eyes and mouths. He also made spontaneous comments about witnessing violence between his parents.

  I responded to Lenny's violent and aggressive themes by commenting in a non-judgmental and caring manner about his actions and the feelings he may have been experiencing (e.g., anger, confusion, fear, hurt). I also responded to people and other characters being hurt with concern and medical attention using a toy medical kit.

  Themes of violence and aggression had all but disappeared by the fifth month of play therapy suggesting a decrease in Lenny's level of anxiety and a lessening preoccupation with frightening and/or confusing events from his past home environment. Interestingly, the disappearance of themes of stuffed animals being spanked for toileting accidents coincided with the completion of toilet training of his younger sister several months into play therapy. During our conversations, Lenny's aunt had expressed considerable frustration with this process. Parenting concerns about Lenny's aunt will be discussed later.

- ***Power/control vs. powerlessness/helplessness.*** While a desire to feel powerful and in control are common amongst children of Lenny's age, his previous chaotic home

environment and the lack of a consistent, dependable caregiver prior to separation likely exacerbated this need in Lenny. For Lenny, these issues were most apparent in his continuous disregard of his aunt's attempts at limit-setting at the beginning of play therapy sessions when he would run to the playroom without her permission and sometimes before I was even in the room. They were also apparent at the end of play therapy sessions when he had difficulty leaving. This did not lessen over the course of treatment.

In play, Lenny seemed to have a need at times to identify with strong, powerful figures in control of their environment such as a "wrestling man" who successfully fought other figures, a shark who refused to stop biting me, and a monster who ate mothers and babies. During some sessions, he became a police officer who arrested "bad" characters for misbehaving (e.g., fighting, stealing, toileting accidents), spanked them and sent them to jail for a "time-out".

At the same time, Lenny's feelings of powerlessness and helplessness were reflected by play themes of characters (including grandfathers, mothers, fathers, aunts, dogs and generic men and women) being unable to help or rescue a cowboy caught in a slinky or a king and queen doll calling for help from the castle. During one early play session, Lenny hid under the table and began to call for help. When I responded with concern and asked him what was wrong, he covered his face and would not answer. On several occasions, he called me on a toy telephone activating a voice that said, "Emergency" but was then unable to speak and ask for help.

I responded to Lenny's themes of power/control vs. powerlessness/helplessness in a non-judgmental, caring and empathic manner by again commenting on his actions

and the feelings he may be experiencing. As our play therapy sessions progressed, I began to introduce the possibility of different endings to the scenes that he enacted, for example, by promoting the strength and capability of some characters to help other characters and by role-playing for him what to say on the telephone in an emergency situation.

Lenny's imaginative play, while it remained lacking in richness, increasingly involved happier, more positive outcomes to conflict between characters he created, with vulnerable characters being partially or completely assisted and rescued by other characters. For example, during a play therapy session two months into the course of treatment, a mother figure continued to be "too weak" to protect a male figure from being assaulted but a grandfather figure was able to protect him. Five months into treatment, Lenny drew a picture of a turtle that was being "sucked down" into the ocean. He then drew a boat that came and saved the turtle. After he completed his drawing, Lenny stood up and took a bow. In response, I clapped and commented that the turtle could count on the boat to look after him. In addition to more positive shifts in metaphorical play, Lenny increasingly allowed himself to be cared for in situations when he pretended to be hurt, suggesting a lessening of his feelings of helplessness.

- ***Sadness and anger in relationship to loss, abandonment and general family dynamics.*** Lenny initially made frequent references in play to feeling sad or angry about not having a mother or father. For example, he made a "sad monster" out of play-doh and commented that the monster was sad because he did not have any parents. On another occasion while making a monster out of play-doh, he commented

that he was afraid of monsters because they could take parents away and make them never return.

Other characters in Lenny's play, including figures used to represent parents, were often maimed and killed at which point he would change his play activity, usually to an action-based activity such as kicking a beach ball. His abrupt change in activities could be explained a number of ways: as a response to heightened levels of anxiety around issues of separation and loss, as a way of attempting to avoid these overwhelming feelings, or as a self-regulating maneuver to cope with these feelings.

Lenny became better able to express his feelings about his parents and other family members as his "feelings" vocabulary increased over the course of treatment (see Goal Three) but little resolution appeared to take place. This can likely be attributed to his parents' ongoing sporadic visits with him and his sister that seemed to impact negatively on the whole family system.

Most notably, while Lenny's aunt generally reported more positive behaviour by Lenny as play therapy progressed, she continued to report non-compliance and episodic aggressive behaviour by him usually directed towards his younger sister when the children's parents called or visited the home and did not follow through with promises. During play therapy sessions, Lenny's feelings of sadness and anger about his parents were also most evident on these occasions.

Additionally, Lenny's expressions of sadness about being spanked by his aunt increased during these times, suggesting that his aunt found it difficult to cope with Lenny's escalated behaviour as a result of the contact. On one occasion after a visit from his mother, Lenny announced during a session that his aunt said, "Mommy is

stupid". This suggests that Lenny's aunt also experienced difficulty in regulating and buffering the children from her own feelings about the situation.

- ***Nurturing needs.*** In addition to some of Lenny's developmental delays, some of his behaviour during play sessions was suggestive of early childhood emotional and physical deprivation. For example, he displayed great interest in the baby bottles and chose to drink his juice from them on six different occasions. I responded in a safe, non-judgmental manner, encouraging Lenny to take comfort in the act of drinking his juice from a bottle in the presence of a nurturing caregiver.

  During these times, Lenny displayed other regressed behaviour previously discussed. On the sixth occasion that he chose to use a baby bottle to drink his juice, Lenny went to the waiting area to show his aunt. When he returned to the playroom, he announced, "I want to be a big boy now" and poured the juice into a cup to drink. After that time, Lenny did not use the baby bottles again. This sequence of events demonstrates Lenny's use of play as a developmental process during which he moved back and forth along a developmental continuum as a way of discovering individuation and separation (Cattanach, 1992).

3) Assist Lenny to develop a "feelings" vocabulary to enable him to express himself better.

Intervention techniques used to assist Lenny develop his "feelings" vocabulary included making balloon faces; labelling my own feelings, Lenny's feelings and those of characters created by Lenny in play; identifying feelings faces from posters in the playroom; making faces together in the mirror of various emotions; drawing pictures and making up stories about the pictures; and reading Emberley and Miranda's (1997) Glad

Monster, Sad Monster , wearing the face masks contained within the book and talking about times we experienced emotions represented by the masks. By the end of the course of play therapy, Lenny had increased his "feelings" vocabulary significantly. He was able to identify and express feelings of sadness, anger, happiness, hurt, loneliness, worry, pride, feeling goofy, feeling silly, love, rage, frustration and impatience.

One of the purposes of this goal was to decrease the amount of Lenny's aggressive behaviour by providing him with more positive ways to express himself. For a discussion of Lenny's aggression, please refer to Goal Two's play theme of sadness and anger in relationship to loss, abandonment and general family dynamics.

4) Assist Lenny to process his negative and overpowering feelings regarding the separation from his parents, that is, to facilitate the mourning process.

To assist Lenny grieve the loss of his parents, I encouraged him to talk to them on a toy telephone, write them a letter, and talk to the television monitor to send them a message. I suggested additional coping techniques for times when he was feeling overwhelmed with negative feelings (e.g., talk to his aunt, daycare personnel, his nursery school teacher; draw a picture of how he felt; punch a pillow; sing a song; ask for a hug). I validated his feelings of sadness, loneliness, fear and anger about his parents. I also attempted to normalize his living arrangements by talking about different family types and reinforcing the availability of a caregiver in his current home and school environment.

Unfortunately, despite intervention with Lenny's caregiver, it is unlikely that Lenny was able to mourn the separation from his parents successfully given the ongoing sporadic and unsatisfactory contact he experienced with them and given his aunt's difficulty in setting parameters around the visits.

Additionally, the inability of Lenny's aunt to tolerate Lenny's acting-out at these times and her inability to process her own feelings around the behaviour of the children's parents lessened her ability to assist Lenny in the process of mourning. Steinhauer (1991) notes that mourning for the child is likely to be unsuccessful if the adults in the child's life are unable to provide ongoing security, are unable to directly and repeatedly confront the reality of the child's loss, and are unable to tolerate the child's expressions of helplessness, rage, and despair generated by the loss (p. 40).

5) Encourage the normal development of empathy for others' feelings by verbalizing and demonstrating emotions in response to actions within an environment of tolerance and acceptance.

The main intervention techniques used with Lenny in this regard were role modelling and labelling of feelings. Lenny responded appropriately to both positive (e.g., happy to play together) and negative feelings (e.g., sadness at termination, hurt when hit in the face with a ball) that I expressed during play therapy sessions. While this goal was included because of concerns voiced by his caregiver, I did not see any behaviour during play therapy sessions that would suggest Lenny's capacity for empathy was below normal for children of his developmental age. This information was shared with his aunt. I also gave her suggestions for encouraging the healthy growth of Lenny's empathic abilities.

6) Encourage Lenny with mastery of age-appropriate tasks.

During our sessions together, Lenny made repeated comments about his inability to master various tasks (e.g., open lids, manipulate a toy). On these occasions, he would state hopelessly, "I can't do it" or ask me to do it for him after only one attempt. In later sessions, when he frequently participated in drawing activities, he would often express

frustration with his inability to draw a picture in the way he wanted to or would ask me to improve his pictures by drawing them "better". Lenny exhibited advanced drawing abilities in keeping with a child of six or seven. While his frustration around drawing may be attributed to generalized feelings of incompetence, the tone of his self-criticism in this regard was suggestive of an artist's dissatisfaction with his work.

In addressing his feelings of inadequacy, I encouraged Lenny to persevere in his attempts at mastery of age-appropriate tasks (e.g., opening play-doh containers, throwing garbage in the garbage can, drawing, counting, singing, playing ball) and to ask for help as needed. I gave ongoing special recognition to both him and his aunt regarding his creative and athletic talents.

7) Educate Lenny's aunt about normal childhood development and individual children's temperament.

Attempts to educate Lenny's aunt about normal childhood development and individual children's temperament were somewhat successful. Child development information and positive reports about Lenny's behaviour and special talents (e.g., drawing, sports) provided by me, Lenny's daycare and Lenny's nursery school were reasonably successful in reframing her perception of her nephew. Her increased knowledge about normal childhood behaviour was demonstrated in our general conversation as well as by her responses to questions on the Child Behaviour Checklist. When she initially completed the checklist, she reported great concern with Lenny's high activity level, lying, and apparent difficulty and lack of remorse in acknowledging wrongdoing. When completing the checklist ten months later, she reported many

instances of behaviour without concern as she indicated realizing this was normal behaviour for a child Lenny's age.

8) Assist Lenny's aunt to develop parenting skills such as setting limits, responding to behavioural cues, and dealing with sibling rivalry.

Attempts to assist Lenny's aunt to develop her repertoire of parenting skills were less successful for the most part. Despite a lack of concern expressed about Lenny's behaviour by his daycare and nursery school, and despite her increased knowledge and understanding of normal childhood development and Lenny's individual temperament, she continued to view play therapy for Lenny as the best solution to her parenting difficulties.

She conceded that the parenting techniques demonstrated on the videotape (Phelan, 1990) I lent her were, on occasion, effective at bedtime. However, she did not follow through with suggestions I made for handling non-compliance, sibling rivalry and aggressive behaviour. Nor did she follow through with suggestions to attend a parenting course, access a one-to-one parenting support program, or implement a sticker chart reward system. She generally responded to parenting suggestions by stating that they did not work.

Lenny's aunt reported both verbally and on the Parenting Stress Index, less stress in her caregiver role at the end of Lenny's course of play therapy. However, she continued to express frustration at times with Lenny's aggressive behaviour and non-compliance, noting that neither parenting techniques such as spanking and yelling, nor any of the suggestions I made, were effective with him.

9) Assist Lenny's aunt to become more comfortable and confident in her new role as parent to her nephew and niece.

I attempted to provide Lenny's aunt with ongoing positive feedback and encouragement for her new role as parent to two small children. While acknowledging the difficult start both Lenny and his younger sister had had in life, I tried to have her focus on the positive aspects of the children's lives in the present with an extended family member who was able to provide for many of their physical, emotional and safety needs.

In terms of her relationship with the children's parents, I validated and attempted to assist her to process her mixed feelings. I felt unsuccessful in this for the most part. She continued to make the same type of contradictory comments about them when treatment was terminated. For example, she vacillated between stating that she had decided not to allow the children's parents to have any contact with them and reporting that she had allowed the parents to stay in her home for up to a week at a time. She also continued to vacillate in her feelings of anger, disappointment and sympathy for the children's parents with no apparent resolution.

I made concrete suggestions to help her assist Lenny and his sister to deal with their feelings about their parents based on ideas from Fraiberg, Adelson and Shaprio's Ghosts in the Nursery (1980). These included having a picture of the parents displayed in the home; not talking negatively about their parents in front of them or within hearing range; allowing them opportunity to talk about their parents if they wished; reassuring them that they will always be looked after; explaining to them that their parents love them but are unable to look after them; avoiding telling them that their parents were coming for a visit until they actually arrived so they would not feel disappointed if they did not show

up; and avoiding arguments with their parents in front of them. I also suggested that she try to put some parameters around visitation by the children's parents. Unfortunately, Lenny's aunt was able to implement only some of the suggestions made and tended to do so inconsistently.

Evaluation

Play therapy with Lenny was terminated when he was deemed to have met his play therapy goals to the extent possible given his developmental age and home environment. The latter was characterized by a caring adult who, nevertheless, appeared to need additional parenting education and who, additionally, continued to have difficulty buffering Lenny from the negative impact of his parents' behaviour and her own feelings about their behaviour.

In terms of psychometric testing completed by Lenny's aunt, significant changes were noted from pre- to post-intervention. On the Child Behaviour Checklist (CBCL), T-scores on the overall and Internalizing scales decreased from a clinical range to a non-clinical range. T-scores for the Externalizing scale decreased from a clinical range to a borderline clinical range with both subscales (Delinquent Behaviour and Aggression) remaining within a borderline clinical range (see Table 1).

Because Lenny was not attending school at the beginning of treatment, a CBCL – Teacher's Report Form was not completed. However, in retrospect, it may have been beneficial to have daycare personnel complete a Teacher's Report for comparative purposes. Regardless, information provided by the daycare suggested no significant concerns with Lenny's behaviour either pre- or post-intervention. Nor did Lenny's nursery school teacher - Lenny started and successfully completed nursery school during

Table 1

Summary of CBCL T-Scores for Lenny (Parent Report)

Parent Report	Pre-Intervention	Post-Intervention
Total T-Score	71*	54
Internalizing T-Score	70*	55
Externalizing T-Score	70*	62
Withdrawn	50	50
Somatic Complaints	50	50
Anxious/Depressed	52	50
Social Problems	56	52
Thought Problems	64	50
Attention Problems	63	54
Delinquent Behaviour	67	67
Aggressive Behaviour	70*	58

Note. Subscale T-Scores below 70 reflect behaviours within the normal range. Total T-Scores, Internalizing and Externalizing T-Scores below 64 are within normal range.

*Scores within the clinical range.

the course of treatment - report any concerns. Indeed, she expressed the opinion that Lenny was a bright little boy with special artistic ability. It would seem that Lenny's behaviour was only deemed to be problematic in his home environment. Arguably, this dynamic could illustrate that daycare and nursery school personnel were less attuned to Lenny's behaviour due to the number of children in the environment. More likely, it is a reflection of the level of caregiving skills available in the home, interactional dynamics between Lenny and his aunt, and Lenny's behaviour in this particular environment, especially at times when Lenny's parents had contact with the household.

The above information leads me to believe that the lower post-intervention scores are primarily a result of Lenny's caregiver learning to differentiate between some normal childhood behaviour for children Lenny's age and behaviour that warrants concern. This was confirmed by comments from Lenny's aunt on the Consumer Feedback Questionnaire that indicated her realization that Lenny's behaviour was "not as bad as (she) thought" and that she now felt better able to "take things more in stride". It may also be partially explained by improved perception by Lenny's aunt of Lenny facilitated by her own learning and positive feedback from various sources including the daycare, Lenny's nursery school and me.

This is not to say that Lenny's behaviour may not also have simultaneously improved in the home environment. Lenny seemed to respond positively to the consistency, regularity, attention, nurturing and opportunity for cathartic play offered by the play therapy process. However, it is difficult to equate changes solely to the play therapy intervention. Changes in Lenny's behaviour may also be attributable to a positive

nursery school experience, a distancing from past painful events, decreasing contact with his parents, and maturation.

I attribute ongoing concerns by Lenny's aunt with some of Lenny's externalizing behaviour including aggression to a number of factors. These include her difficulty mastering effective behaviour management strategies, especially regarding sibling rivalry, ongoing lack of resolution for Lenny's aunt regarding the children's parents, her consequent inability to buffer the children from the parents' inconsistent behaviour and her own inconsistent behaviour during times of stress, and the continued use of spanking as a disciplinary method in the home.

These conclusions, that is, that the primary dynamic of continuing difficulties in this family is more likely associated with caregiver attributes, interactional attributes between caregiver and child, and child attributes as perceived by the caregiver, rather than solely child attributes, appear to be supported by scores on the Parenting Stress Index (PSI) (see Table 2). The scores showed only minor decreases across all but one subscale (which remained the same), Total Scores for both Child and Parent Domains, and Total Scores for stress. Decreasing scores indicate decreasing levels of parental stress.

Scores on the Child Domain subscales of Distractibility/Hyperactivity, Reinforces Parent, and Demandingness remained within the clinical range, as did the Total Score for Child Domain. Other Child Domain subscale scores (Adaptability, Mood) fell to within borderline clinical range. The Child Domain subscale of Acceptability remained within the non-clinical range. Parent Domain subscale scores remained within non-clinical range (Isolation, Health), remained within the clinical range (Role Restriction) or fell to within

Table 2

Summary of PSI Scores for Lenny and his Caregiver

Child Domain	Pre-Intervention	Post-Intervention
Distractibility/Hyperactivity	35*	30*
Adaptability	31*	27
Reinforces Parent	16*	14*
Demandingness	29*	27*
Mood	16*	10
Acceptability	13	12
Total for Child Domain	140*	120*

Parent Domain	Pre-Intervention	Post-Intervention
Competence	38*	23
Isolation	16	16
Attachment	17*	14
Health	14	11
Role Restriction	24*	21*
Depression	**	**
Spouse	N/A	N/A
Total for Parent Domain	154*	110*
Total Stress	294*	230*
Life Stress	10	0

* Scores within the clinical range

** Insufficient data

borderline clinical and non-clinical range (Competence, Attachment). Total Score for the Parent Domain remained within the clinical range. This, in turn suggests that Lenny's aunt, despite feeling somewhat more confident in her parenting role and somewhat more positive towards Lenny in general, still felt frustrated by behaviour incompatible with her expectations of the child and her abilities to manage.

In conclusion, more intense work with Lenny's aunt regarding parenting and processing of her own feelings about Lenny's parents may have been beneficial especially in terms of facilitating a more successful mourning process for Lenny. Unfortunately, she was reluctant for the most part to participate in a learning and/or therapeutic process for herself. Additional work with Lenny and his aunt together using a modified Filial Therapy approach and/or a modified Theraplay approach might have been beneficial in encouraging mutual attachment behaviours.

Despite some resistance to learning for herself, Lenny's aunt consistently brought Lenny for his play therapy appointments. She expressed affection towards him at times, great pride in his accomplishments, and a growing understanding of normal childhood development and Lenny's individual temperament and needs. It is likely that Lenny as well as his aunt will continue to process issues over the life span related to their relationship with Lenny's parents.

Annie

Background Information

Annie was referred for play therapy due to concerns about her social difficulties; a troubling preoccupation with themes of violence, injury and sexualized relationships; and conflict and confusion around intimate relationships. According to information provided

by Child and Family Services, Annie was placed in their care briefly at the age of four after one of her mother's partners physically assaulted her and her mother. This partner also reportedly killed Annie's cat in front of her. Annie was returned to her mother's care shortly after this event when her mother agreed to separate from the perpetrator.

Annie and her two younger brothers (twins) born approximately six months after Annie was returned to her mother's care the first time, were apprehended a year later due to continued concerns of physical and emotional abuse (by their mother and mother's subsequent partners), sexual abuse (Annie's disclosure was unclear regarding the specific nature of the abuse and the perpetrator, and the twins were pre-verbal), neglect, domestic violence, exposure to adult sexual activity, and parental substance abuse. Unfortunately, the agency was unable to find a foster placement for all three children together. Annie was placed separately with a couple in the city who had two adolescent daughters.

During this time, Annie continued to have twice-weekly visits with her birth mother and siblings that were supervised by agency personnel. Annie's behaviour during these visits was described as angry, aggressive, bossy and controlling towards her birth mother. During some visits, she told her birth mother that she hated her and threatened to kill her. The visits were eventually reduced to once a week and then bi-weekly. Annie was made a permanent ward of the agency when she was six years old and visits with her birth mother were terminated. She was recently moved to a long-term foster placement a week prior to her seventh birthday. Her present placement is with a couple who have no other children in their home.

Initial Assessment

While Annie entered the play therapy process having already been assessed by a psychologist, information about her functioning was also gathered from collateral sources including her Child and Family Services social worker and her foster mother. These sources described Annie's behaviour as aggressive, manipulative, attention seeking and sexualized. She was noted to have difficulty establishing and maintaining positive relationships with adults and other children. Underscoring the findings of the psychological assessment, Annie also appeared to experience ambivalent feelings about children and their care, confusion and conflict around intimate relationships, and a troubling preoccupation with violence, injury, sexualized relationships and social conflict.

Initial play therapy sessions with Annie were also used for assessment purposes. Upon meeting, she did not speak and avoided eye contact but allowed me to shake her hand. She separated easily from her foster mother who initially accompanied her to the playroom. Annie quickly became engrossed in play and did not acknowledge her foster mother when she left the room. She refused my offer of juice and cookies.

Annie did not respond to comments and questions about why she had been brought to play therapy. She chose to play with the toy kitchen, immediately assigning me the role of husband and later daughter and directing what I should say and do in these roles. She continued to make little eye contact with me for the most part. Her speech was sometimes difficult to understand. She became irritated if I initiated an action without her direction or did not understand her directions. She also became annoyed when, attempting a child-focused play therapy technique for the first time, I reflected on what she was doing. Initially, she responded by saying, "I know". She later told me stop

doing it. At one point when I asked her to repeat herself, she yelled impatiently, "What - am I speaking French?" The only time Annie seemed to make eye contact was when she was angry. At these times, she appeared to be glaring at me. At the end of the first session, Annie still declined my offer of juice but furtively took a long drink from one available before leaving.

Annie's predominant affect in the initial sessions included anxiety, distrust and anger with an overt need to control the interactions in her environment. Her manner of relating seemed hostile and was characterized by the use of distancing. While she seemed interested in the toys in the playroom, her intensity and lack of apparent enjoyment in play was characteristic in some ways of Terr's (1991) posttraumatic play. In later sessions, Annie's repetitive play behaviour continued to reflect similar themes noted during her psychological assessment and early play therapy sessions – preoccupation with sexualized relationships, alternating good and poor care of children, confusion and conflict around intimacy, and children in foster care - without apparent resolution. At times during play, Annie would become so caught up in what she was doing that she would seem to forget my presence, frantically and intensely supplying the dialogue for all characters involved in a scene.

In summary, Annie's behaviour was suggestive of an "aggressive attachment disorder" (Zeanah et al., 1993) in which a child views the behaviour of others as malevolent based on experiences of hostile and rejecting behaviour from past caregivers. Delaney (1991) refers to these children as having a "negative world view" and notes that their behaviour tends to elicit abusive and rejecting behaviour from caregivers, which in turn confirms their view.

Goal Setting

The initial goal for treatment then was formulated as:

1) **Develop a relationship with Annie that is based on trust in order to facilitate the other goals.**

Other specific goals for treatment were provided by the Child Protection Centre's psychologist who assessed and referred Annie for long term therapy (i.e., a year or longer):

2) **Assist Annie to work through violent and aggressive themes in order to determine their possible origins and clinical significance, and to enable interventions by the therapist aimed at diffusing conflicts that may be suggested by her preoccupation with such themes. Also, support Annie in dealing with her feelings about the many potentially confusing events and changes that have occurred in her life including her placement in foster care and the circumstances surrounding this need for placement.** The purpose of this goal was to provide an opportunity for Annie for emotional release, adjustment to trauma, developing insight, and developing mastery over her environment (Schaefer, 1993, pp. 6-11).

3) **Assist Annie to appraise more realistically her feelings about others and to deal with these feelings in a healthy manner.** The purpose of this goal was to provide an opportunity for developing understanding through better communication with others and for practicing and acquiring new behaviours that would strengthen self-esteem and attachment behaviour.

4) **Teach Annie more appropriate ways of interacting with others socially.** The purpose of this goal was to provide Annie with the opportunity for growth and development, socialization, the development of empathy and learning to feel close to others.

The following treatment goal was added after meeting Annie and her foster parents:

5) **Support the foster parent's parenting efforts by assisting them to understand both the play therapy process and the psychological dynamics behind Annie's behaviour.** The purpose of this goal was to minimize the likelihood of unhealthy caregiver dynamics developing in Annie's foster home that would replicate her earlier experiences of abuse and neglect.

Therapeutic Interventions and Outcomes

The following is a synopsis of the therapeutic interventions and outcomes with Annie:

1) **Develop a trusting relationship with Annie in order to be able to facilitate the other goals.**

In fostering the development of a trusting relationship with Annie, as with any child with an attachment disorder, consistency, reliability and patience were paramount. Therapist behaviour that promoted the fostering of a trusting relationship included:

- Scheduling play therapy appointments at the same time in the same playroom every week.

- Sending cards to Annie at times when appointments were cancelled to let her know I was thinking about her.
- Helping Annie to make her soup for her lunch when she brought it with her.
- Responding to Annie's negative behaviour (e.g., bossiness, anger, impatience, occasional hitting, temper tantrums) calmly, consistently, and non-punitively.
- Telling Annie that I liked spending time with her regardless of her behaviour.
- Telling Annie that there was no behaviour she could show me that would make me not want to see her again.
- Giving Annie stickers every week regardless of her behaviour.
- Respecting Annie's limits in talking about painful subjects.
- Giving Annie presents on special occasions that were chosen for her with her own personal tastes in mind.

The development of trust with Annie was and continues to be a slow process. Annie was extremely careful in sharing her vulnerable feelings and frequently seemed to be attempting to provoke rejecting behaviour by acting rudely, defiantly or dismissively. My attempts to offer support and nurturance (e.g., kind words, cookies and juice, expression of positive feelings about her) were usually rejected or ignored. Themes of play in which adults were initially nice to children then behaved unkindly towards them, laughing at and grounding them, suggested to me that Annie perceived my overtures as "tricks".

Without completely resolving trust issues, a turning point, nevertheless, occurred during our 16th session. During our previous session, Annie had a temper tantrum in which she repeatedly told me I was mean and that she hated me. This occurred in the context of her not wanting to finish her activity and leave the playroom at the end of our time together. She had alternately yelled that she was never leaving the playroom and that she was never coming back. She left the playroom with her anger unresolved.

At the beginning of our 16th session, Annie appeared unusually quiet and reported that her tummy was upset. We began to colour together at Annie's initiative at which point I suggested we sing a song. Annie initially resisted but then agreed to listen. I sang You Are My Sunshine. Annie immediately asked me to sing the song again. She continued to have me sing the song over and over again for the remainder of our time together, at times joining in. During our singing, she reported that her nickname was "Sunshine". This was confirmed at a later date by a letter she received from her mother. At the end of our session, she said, "You've made my tummy feel better". In subsequent sessions, You Are My Sunshine became a way of soothing Annie when she was having a bad day, re-connecting and signalling that everything was "okay" after she had a tantrum, or simply a way of enjoying ourselves together during a shared activity.

Another opportunity for the development of trust occurred during washroom breaks. While Annie used the toilet, I told her I would remain outside by the sink adjusting the temperature of the water for her to wash her hands afterwards. Annie accepted my nurturing behaviour with giggles and directions for adding more hot or more cold water and then choosing which paper towels she was going to use to dry her hands. Sometimes, she enjoyed having me put lotion on her hands afterwards.

2) Assist Annie to work through violent and aggressive themes in order to determine their possible origins and clinical significance, and to enable interventions by the therapist aimed at diffusing conflicts that may be suggested by her preoccupation with such themes. Also, support Annie in dealing with her feelings about the many potentially confusing events and changes that have occurred in her life including her placement in foster care and the circumstances surrounding this need for placement.

Annie's play was rich in metaphorical themes. Throughout our play therapy sessions, starting with our first one, she used dolls, the dollhouse, the castle and the jail to enact scenes of children being left alone, daughters being kept in jail or torture chambers away from their families, daughters not being able to find their way home, women and men kissing and having sex, boys and girls "open-mouth" kissing, women and men fighting and hurting each other, and babies being alternatively cared for and abused or neglected. Foster children were often incorporated into her play as characters that were "bad", did not belong or were not wanted.

During early play therapy sessions, my role as a therapist focused on relationship building, discovering and understanding Annie's concerns, and providing a non-judgmental environment in which she could explore difficult themes from her life experiences distanced from reality by the act of playing. During this time, Annie was able to tolerate little direct discussion of her past chaotic home life or current issues she was experiencing in foster care and attempts to elicit discussion on these subjects were met with anger, defiance or avoidance. My suggestions and attempts to provide new options

or solutions to Annie's painful play themes, initiated only after several months of sessions, were met with similar resistance.

During our fifth session, Annie initiated pretend play in which she was the mother and I was the daughter. This mother-daughter game continued intermittently throughout our sessions, becoming a focus for Annie during stressful times in her life (e.g., visits with her birth mother, when visits with her birth mother were terminated, Christmas, just prior to her move to another foster home). An imperious statement of "Daughter!" usually heralded the beginning of each game in which Annie as the mother alternated between benevolent and unkind behaviour towards me as the daughter.

The mother's benevolent behaviour in this pretend play generally took the form of practical caregiving behaviour such as making a meal for the child (albeit, food the child did not like at times) or buying the child a toy at the store. Unkind behaviour was predominant with the mother frequently ignoring the child, ridiculing her, leaving the child alone or with abusive caregivers, threatening to leave her with babysitters, taking the side of a visiting friend who had hurt the child's feelings, sending the child to jail, punishing the child with groundings, verbal abuse, taking toys away, and hitting (limits had to be set around pretend play in this regard).

One of the noticeable themes in Annie's mother-daughter play was her angry demand for the daughter to respond to confusing and conflicting directives. For example, she would frequently tell the daughter to do something (e.g., wash the dishes) then angrily tell her not to, only to become even angrier when the daughter stopped washing up. On other occasions, she would tell the daughter to take money from her purse to go shopping but then accuse the daughter of stealing, order her to wash up without using

water or change her mind several times about allowing the daughter to play or leave her room.

On the occasions that Annie made impossible demands of the daughter, she also frequently became bossy, angry and impatient with me outside the realm of pretend play. These occasions seemed to coincide with the days she also had visits with her mother before coming for play therapy. Annie would become outraged with me for almost any reason such as looking at her, not looking at her, not saying anything, talking too much, copying her, asking her to repeat something I had not understood, not drawing a picture the way she wanted me to, or standing on the floor after she had told me I was not to have my feet on the floor. My expressions of confusion only seemed to exacerbate her anger.

Distraction, sincere attempts to please her and using humour eventually emerged as effective ways of dealing with Annie under these circumstances. For example, suggesting another activity, remaining quiet and moving to another corner of the room or changing the topic of conversation sometimes halted her tirades. The second time that she demanded I not stand or sit on the floor, I stood on my head. When she decreed that this was unacceptable, I flapped my arms and pretended to fly which eventually made her laugh.

During a number of subsequent play sessions, Annie laughingly made reference to my attempts at flying. Her unreasonable demands and tirades decreased significantly after this point until Annie was moved to another foster home. During her first session after the move, Annie became angry because I was not tracing her properly on a big piece of paper as she requested. Her behaviour escalated but was thwarted by distraction. After

assuring her that I was not angry with her, she was, in contrast to previous episodes, able to discuss what happened and how other people reacted to her when she became angry (i.e., sent her to her room).

As the daughter during pretend play, I increasingly started to express the many mixed feelings a child would experience in the situations Annie had us enact: anger, sadness, fear, guilt, confusion, rejection, hope, self-blame, gratitude, relief and frustration. Initially Annie was unable to tolerate much expression of these feelings and would tell me angrily to be quiet or shut up. As Annie's tolerance increased, she was able to prompt me at times in what feelings I should express.

After approximately eight months of play therapy, Annie's tolerance had increased substantially allowing her to listen to virtually all of the feelings I expressed as the daughter and, occasionally, to respond to them in a nurturing or otherwise positive manner. For example, on one occasion, she sent the daughter to jail for being bad and refused to visit her. When I expressed feeling lonely for my mother, wondering what I had done to make her not visit me and wishing I could see her, she said soothingly and in marked contrast to her previous harsh tone, "I'll come to visit you one day". On another occasion when the daughter had been banished and the mother refused to visit her, I expressed the worry that my mother did not love me. I added, pouting, that if my mother did not love me then perhaps I would forget about her. Annie hastily told the daughter that she loved her. On yet another occasion when I expressed negative feelings about being told what to do (as the child), she said gently, "I'm not being mean – I just want you to do this".

Annie became angry during early play therapy sessions if I attempted to talk to her outside our pretend roles and often refused to respond to questions about circumstances in her own life that paralleled her pretend play. As with her ability to tolerate my expression of feelings within the context of pretend play, Annie was gradually more able to tolerate exploration of her past and present circumstances without the use of metaphor.

I found that the most effective ways to elicit responses from Annie were to ask questions in a whispered voice usually while playing and just prior to the end of the play session. In this manner, Annie was able to talk briefly about her mother's boyfriend killing her cat; hurting her, her siblings, and her mother; her mother yelling at her and making her "pee on the carpet"; her mother trying to kill her; and trying hard not to get grounded in her foster home. She was also able to express how confused she felt about not being able to see her birth mother, moving to a foster home, and then moving to another foster home.

3) Assist Annie to appraise more realistically her feelings about others and to deal with these feelings in a healthy manner.

Interventions for this goal were similar to the exploration of metaphorical play used to achieve the second goal. During doll play and pretend play of mother-daughter, I consistently expressed a wide range of feelings about different people (e.g., mother, foster mother, other children) as a means of acknowledging the possibility of holding more than one feeling (often conflicting) about a person at the same time. While initially resistant, Annie was eventually able to join in and prompt me in the expression of these feelings.

Annie seemed to have particular difficulty dealing with her feelings about her birth mother and foster mother attributing to them at different times either totally positive or totally negative traits. For example, at times, Annie would describe her birth mother as someone who was nice and who cared for her. She would express longing to be with her at these times. On other occasions, she would describe her birth mother as bad or mean. Annie also spoke about her foster mother in these extreme terms.

The primary intervention for assisting Annie to accept conflicting feelings about her birth mother was to accept her need to talk or not to talk about her at times. This included gently suggesting that some of her anxious or negative behaviour may be connected to her thinking about her mother at certain times, accepting this behaviour but also making suggestions for expressing her feelings more appropriately.

For example, during the weeks following Annie's good-bye visit with her birth mother after Child and Family Services obtained permanent guardianship of her, Annie's difficult behaviour escalated and her tolerance for direct talk about her birth mother decreased. During our 22nd session, the second session after she had her good-bye visit, Annie continued to avoid discussion of her birth mother or the visit and expressed anger towards me when I attempted to introduce the topic.

Her barely metaphorical play of mother-daughter was intense with the mother giving negative messages to the daughter that she was not her mother and banishing her daughter from home for being an "idiot". As the play session wound down, Annie suddenly grabbed a toy telephone and started a long process of calling her birth mother only to learn she was not home. When she was eventually able to speak to her, she could be heard promising to be good and begging to be allowed to come home.

I gently reflected back to Annie that she was thinking about and missing her birth mother. She let me talk without interrupting about her birth mother having adult problems that stopped her from being able to look after her. Annie then quietly let me help her put her tights back on that she had taken off at the beginning of our session. We spent subsequent sessions writing letters to her birth mother and drawing her pictures while processing her birth mother's inability to look after her.

4) Teach Annie more appropriate ways of interacting with others.

For this goal, I demonstrated as the child during pretend play and doll play, different ways of interacting with others in a way that was both acceptable and met my own needs. For example, in pretend play as a child with other children, I expressed both positive (e.g., liking them, wanting to play with them, thinking they were fun) and negative feelings (e.g., not liking them, not wanting to play with them, wondering why they were being mean to me) about the other children dependent on their behaviour and my feelings. I then acted accordingly and processed the manner in which the other children responded to me (e.g., "I guess she didn't like me telling her what to do all the time", "I guess she thought I was tattling on her"). On one occasion, during our 31st session, Annie tolerated listening to Berenstain and Berenstain's (1987) The Berenstain Bears and the Trouble with Friends about a bossy six-year-old girl. In previous sessions, Annie had refused to read any books or have me read any books to her.

5) Support the foster parents's parenting efforts by assisting them to understand both the play therapy process and the psychological dynamics behind Annie's behaviour.

Annie's foster parents initially presented as somewhat uneasy about Annie participating in play therapy, expressing more doubts about its benefit to Annie as the process progressed. It was my sense that attempts to engage them in the process through support and validation, feedback about play therapy sessions, behavioural management suggestions, and education about the play therapy process and Annie's issues were unsuccessful in helping them to develop an understanding of the role of play therapy and her foster child's needs.

When support and education around Annie's needs proved ineffective, advocacy for a foster placement that would better meet Annie's special needs became part of the play therapy process. Annie was moved to a new foster home two years after her initial placement in care and 13 months after she started play therapy.

Evaluation

Due to the nature of Annie's difficulties, she was referred for long-term play therapy, that is, for a duration of a year or longer. Play therapy with Annie continued past the end of the practicum process and therefore post-intervention measures were not completed at the time of writing.

Annie's foster parents had expressed reluctance at the beginning of the treatment process to complete a CBCL and a PSI, stating that they had already done so for Annie's previous psychological assessment. They did eventually agree, however, to complete a CBCL at the beginning of treatment and for mid-intervention comparative purposes ten months into the course of treatment.

I was able to obtain a copy of the PSI results from the assessing psychologist. Unfortunately, little could be extrapolated from the information provided as Annie's

Table 3

Summary of CBCL T-Scores for Annie (Parent Report)

Parent Report	Pre-Intervention	Post-Intervention
Total T-Score	78*	77*
Internalizing T-Score	87*	85*
Externalizing T-Score	85*	87*
Withdrawn	60	52
Somatic Complaints	53	50
Anxious/Depressed	64	67
Social Problems	78*	78*
Thought Problems	82*	76*
Attention Problems	82*	78*
Delinquent Behaviour	76*	79*
Aggressive Behaviour	98*	98*

Note. Subscale T-Scores below 70 reflect behaviours within the normal range.

Total T-Scores, Internalizing and Externalizing T-Scores below 64 are within normal range.

*Scores within the clinical range.

foster parents had failed to respond to more than one third of the questions. In retrospect, I perhaps should have insisted that they complete another PSI but given my eagerness to forge a working alliance with them, I did not.

In terms of the CBCL, no significant changes were reported within the ten months Annie participated in play therapy (see Table 3). Overall, Internalizing, and Externalizing T-Scores pre-intervention and mid-intervention all fell within the clinical range. Both subscale scores for the Externalizing Behaviours measure (Delinquent and Aggressive Behaviour) fell within the clinical range at pre- and mid-intervention as did subscale scores for the Internalizing Behaviours measure (Social Problems, Thought Problems, Attention Problems). However, several subscale scores for the Internalizing Behaviours measure (Withdrawn, Somatic Complaints, Anxious/Depressed) fell within a non-clinical range pre-intervention. While the subscale scores of Withdrawn and Somatic Complaints remained within non-clinical range, the subscale score for Anxious/Depressed increased to within a borderline clinical range.

Because Annie started play therapy during the summer, her teacher was not asked to complete pre-intervention test measures. Nevertheless, I had contact with her on a number of different occasions once the school year began. Interestingly, information she provided about Annie contrasted significantly with the foster parents' descriptions of her. For example, the foster parents reported that Annie had no friends because nobody (i.e., children and adults) liked her. In contrast, Annie's teacher endorsed "Not True At All" on a behavioural checklist used for comparative purposes for the following items: "Appears to be unaccepted by group", "Is one of the last to be picked for teams or games", and "Has no friends". She also expressed warm feelings for Annie and let me

know that the vice-principal in the school and her husband were interested in adopting her.

Annie's foster parents also reported that Annie was extremely disruptive in the classroom. In contrast, Annie's teacher indicated that Annie could be "loud" and difficult to manage at times but that she was not nearly as difficult to manage as another very troubled child in the classroom. She felt the interaction between Annie and the other child was problematic, noticing a significant decrease in Annie's problematic behaviour after this child moved to another school. Annie's teacher also noted that her behaviour tended to be more difficult after she had spent time in a respite home or attended a play therapy appointment. She added that Annie frequently spent time in respite homes. She also reported that Annie's reading skills were significantly delayed and that she did not seem to receive assistance in her foster home.

These findings did not surprise me. Annie's foster parents continued to describe Annie's behaviour in extremely negative terms at the time of the mid-intervention measurement. Their descriptions continued to suggest that they had developed no insight into the child's behaviour and that they had, in fact, developed an angry, blaming and punitive attitude towards her. Their rigid, behaviour-focused parenting style clashed sharply with Annie's need for control resulting in ugly power struggles and rejecting behaviour by the foster parents.

It was my impression that Annie's behaviour during play therapy demonstrated a slowly growing trust in the therapeutic relationship. Her school environment also appeared to be positive for her. Unfortunately, I believe that such a small chink in the armor of a heavily defended, attachment-disordered child was not sufficient to accomplish

major therapeutic change while she remained in an emotionally abusive, rejecting home environment. It will be interesting to see how Annie's treatment progresses now that she has moved to a new foster home with two adults who have presented warmly and positively towards her, and to the play therapy process, upon preliminary contact.

THEMES: IMPLICATIONS FOR CLINICAL INTERVENTION

Throughout the practicum process, general themes emerged which have implications for clinical intervention with children who have been abused or neglected.

The Therapeutic Relationship

In reviewing the play therapy literature at the start of this practicum process from Axline (1947, 1964) to Zeanah et al. (1993), it became apparent that virtually all clinicians and researchers believe that the relationship between therapist and child is the foundation of a successful therapeutic process with any population. One of my learning objectives in developing my ability to provide play therapy for maltreated children was to learn how to build on this foundation to facilitate the healing process and effect change. While additional therapeutic work can most definitely be accomplished after the establishment of a positive therapeutic relationship, I realize now that the building of such a relationship in and of itself constitutes a major therapeutic intervention.

Developing a therapeutic relationship with children who have been abused or neglected is challenging given their learned understanding that relationships result in psychological and physical pain. Due to their experiences of inconsistent, unavailable and, at times, hurtful caregivers in the past, they are likely to have an impairment of their attachment systems characterized by negative internal working models (Bowlby, 1982), a negative worldview (Delaney, 1991), and, in turn, maladaptive behaviour patterns.

The establishment of a positive therapeutic relationship with such a child accomplishes a significant therapeutic task in that the child is given the opportunity to experience a positive relationship that provides a contrast, and thus, an exception, to her

or his negative expectations. This is the first step in changing the child's internal working models and negative worldview.

In this context, the therapeutic relationship can be used to examine the internal working models and expectations that the child brings to the relationship. Later, using the relationship as a secure base, the child can be helped to explore the painful aspects of past and present relationships and to modify internal working models that are not accurate. This, in turn, results in a healthier working model of relationships with others, making the child's maladaptive behaviours obsolete.

The establishment of a positive relationship was a significant part of my work with Annie, a child demonstrating signs of an aggressive attachment disorder. Annie, I believe, used the therapeutic relationship, which is, according to Cattanach (1992) representative of Winnicott's transitional space (1975), to move back and forth along the developmental continuum as she strove for healthy individuation and separation from a non-abusive and non-punitive adult.

In a similar manner as toddlers exploring the world using their caregivers as a secure base, Annie was able to "try on" different behaviours with the therapeutic relationship as a safety net. For example, at times, she was bossy, dismissive, verbally abusive and physically aggressive. At other times, she was giddy and silly. On a number of occasions, she appeared to be acting provocatively (e.g., wanting to wear her dress off her shoulders, sitting and lying down in ways that revealed her underwear, coming out of the washroom cubicle with no clothes on, making sexual noises during doll play).

During our 18th play therapy session, following a previous session in which she had expressed a great deal of anger towards me, Annie climbed onto my lap, remained

there for about 20 minutes giggling and happily eating a Halloween cookie I had made for her. At times, she laughed and threw herself backwards necessitating me having to grab her and ensure she did not fall – a child's simplistic way of discovering if the adult she was with was trustworthy. A significant part of the therapeutic process, then, involved accepting all of Annie's behaviours in a calm, non-punitive, non-exploitive manner and, at times, commenting on them and initiating exploration of their meaning and context without judgement.

The contribution of a positive therapeutic relationship to changing a child's internal working models, negative worldview and eventually, maladaptive behaviours may be simple and straightforward. For example, a positive contribution included focusing attention on Lenny, previously "unseen" in a neglectful home environment, by telling him, "I'm watching you!" and suggesting he show me how high he could throw a ball before he needed to elicit my attention in more negative ways. For this same reason, Lenny also benefited from playful, nurturing physical contact initiated by the therapist or in response to playful overtures from Lenny, thus precluding the necessity of acting-out behaviour.

Another example involved play therapy with seven-year-old Curtis, who had not had contact with his mother for five months prior to the start of play therapy. He became anxious and confused when his mother reconnected with him two months into his course of treatment and initiated a long, drawn-out court process to regain guardianship of him. The therapeutic relationship provided respite for Curtis from the behavioural expectations and pressures of both his foster home and mother's home during this time especially given his belief that he needed to be "good" in order to return to his mother's care.

While both sets of parents encouraged Curtis to use our time together to talk about how he felt, I gave him the message that I would be available to listen to him whenever he felt ready to talk. I let him know of my experiences with other children in foster care with mixed feelings and divided loyalties. Although unable to put his own feelings into words, Curtis indicated with relief identification with these other children's feelings. Limited exploration and processing of Curtis' feelings began to take place in later play therapy sessions.

For all of Annie's hostility, Lenny's detachment and Curtis' avoidance of issues, it was 11-year-old Tracy with whom I found it the most difficult to develop a meaningful therapeutic relationship. As therapy progressed, I sensed that Tracy became increasingly more comfortable with me but I did not sense a deepening of the relationship. I attributed this to her constricted range of emotional affect - subdued smiles and giggles, mild embarrassment, tempered enjoyment, apparent boredom - making her manner of relating seem somewhat distant and superficial.

Tracy was not a difficult child with whom to work but she was a difficult child with whom to engage effectively. In contrast to the other children, she easily accepted guidance and direction during our sessions. She generally asked at the beginning of each session what activity I had planned. Tracy was pleasant and cooperative at all times. She seemed to enjoy arts and crafts activities, doll play and play with the dollhouse. She also readily engaged in therapeutic games such as "The Angry Monster Machine", "The Talking, Feeling, Doing Game", "Up and Down with Feelings", "My Homes and Other Places", and a storytelling game called "Once Upon a Time". These games are designed to facilitate the creation of stories and other fantasy material of therapeutic value and to

engage children in psychotherapeutic dialogue (Gardner, 1983, pp. 259-260). Gardner (1983) provides guidelines for therapists who must take turns with the child answering the games' questions. Specifically, he writes that, "Each response is tailored to the particular needs of the child (Gardner, 1983, p. 263). With Tracey, I was able to respond to questions in a manner that facilitated discussion about family of origin issues, violence, alcohol use, relationships with other children, school, and self-esteem.

While at times she avoided answering questions about her past and present experiences by stating, "I don't know" or that she did not remember, more often than not, she supplied reasonably full responses to my questions and comments. At times, she allowed for limited cognitive exploration of feelings. On occasion, she talked about feeling angry but without affect. Specifically regarding exploration of her "anger style" (Potter-Efron & Potter-Efron, 1995), her responses on behaviour checklists and during discussion suggested that she had an avoidant manner of dealing with these feelings. At times, the hidden intensity of her feelings was revealed by comments made during play. For example, on one occasion, she pointed to a crying doll's face and stated that the mother must have told her she did not like her and that she was bad.

In summary, Tracy appeared to be going through the motions of therapy but without a more developed therapeutic relationship, I questioned her ability to benefit from it. In coming to view the development of a positive therapeutic relationship as a major therapeutic task in and of itself, I worried that no significant shift could occur in Tracy's internal working models and negative worldview.

As a novice therapist, I found myself torn between the idea of trying to re-establish contact for Tracy with her repressed feelings (Steinhauer, 1991) and respecting

her defenses. I worried, too, that I may have been colluding with her avoidance of feelings in an attempt to protect my own feelings (Steinhauer, 1991). Because of the relatively short-term nature of this intervention, I chose the latter course, concluding that "feelings" work of the intensity hinted at by Tracy's history and need to repress, would likely require extensive, long-term, skilled intervention and therapeutic, supportive parenting unavailable from her current caregivers.

One of my learning objectives for this practicum was to become competent in offering support and education to caregivers of children engaged in play therapy while still respecting the therapeutic relationship with the child. I found this to be one of my more challenging objectives. Guerney (1983) notes that, "A child should be guaranteed that what goes on (in the playroom) will not be communicated by the therapist to anyone else" (p. 46). Guidelines regulating therapists' professional conduct (CASW, 1994) also underscore the importance of a client's right to confidentiality.

However, having worked in a variety of roles within the child welfare system, I am very aware of the importance of understanding and cooperation among people involved with a child. When working with children, communication with caregivers is usually an essential part of the treatment plan. Caregivers need to develop an understanding of their children's feelings and behaviours and learn to respond in an appropriate manner. In my experience, I often found parents, foster parents and child welfare workers frustrated by a therapist's reluctance to share information about a child's play therapy sessions.

Finding a balance in terms of what and how much information to share with caregivers is a difficult but important task. It is imperative to respect the child's privacy

yet at the same time provide sufficient information for the child's caregivers to respond to the child's needs appropriately. Generally speaking, I discovered during the practicum process that confidentiality tends to be less of an issue with younger children. Perry noted that pre-school children are often used to being discussed by the adults in their life and therefore do not have a general expectation of confidentiality (L. A. Perry, personal communication, 1998). For example, in contrast to a need for privacy and confidentiality, Lenny frequently left the playroom to share toys and activities with his aunt in the waiting area.

Despite this, an issue regarding confidentiality did arise in Lenny's treatment. On the second occasion that Lenny drank from a baby bottle, I mentioned it to his aunt in his presence who reported that he tried to do so at home sometimes also which she discouraged. The following session, Lenny made a point of not drinking from the bottle. I suspected in this instance, that Lenny's aunt had discouraged him from using a bottle during play sessions. While in retrospect, I feel that I should not have shared this information with Lenny's aunt, it became a learning opportunity to discuss with her sibling rivalry, children's need for nurturance and regression when under stress. Lenny's aunt responded in a more supportive manner to a later incident of him drinking from a bottle, better enabling him, I think, to give it up in a positive manner.

School-aged children and adolescents, in contrast, need to know specifically what information will or will not be shared with their caregivers. Trust, safety and control issues frequently exacerbate maltreated children's anxiety about confidentiality. Curtis' foster parents, for example, reported that when they or his foster brothers asked what he did in play therapy, he always replied that it was "private". Fortunately, as skilled,

professional foster parents, they were respectful of Curtis' need for privacy and needed only minimal direction in parenting issues. In retrospect, however, because of my well-intentioned goal of forging a working alliance with the foster parents, and involving them in treatment, I think I may have shared too much information about the play therapy sessions with them.

The foster parents of eleven-year-old Tracy were warm and nurturing people but less therapeutically oriented. They needed some guidance in responding to Tracy's feelings about her family of origin. For example, the foster mother questioned why Tracy became angry with them instead of her birth mother when she failed to show up for visits. They willingly incorporated information I provided on this issue into their parenting without expecting explicit details about the contents of our play therapy sessions.

In summary, the development of a positive therapeutic relationship is not only the foundation for conducting effective play therapy with children, it is also a significant therapeutic task in and of itself. This is especially true when working with children who have difficulty trusting adults due to previous experiences of abusive or neglectful caregiving. While working collaboratively with parents, alternate caregivers and other members of the child's treatment team is important, play therapists need to protect the integrity of the therapist-client relationship by respecting the confidential nature of play therapy sessions.

Transference

Brems (1993) provides a functional definition of transference in that it can accommodate various theoretical frameworks. She writes:

> Transference refers to the fact that there are aspects of the child-therapist relationship that are catalyzed by the therapist's overt and intentional behaviour and less so by her or his covert or unintentional personality style, and that reflect or express a child's unique feelings, needs, and desires, as they were formed through the child's interpersonal environment up to this time in her or his life. (p. 234)

Issues of transference were readily apparent throughout the practicum process and were very helpful in terms of the assessment process and discovering appropriate points for intervention. Annie's way of relating to me, for example, suggested that she viewed the world as "less available and more threatening or hostile than children with secure attachments" (Benedict & Mongoven, 1997) due to neglectful and abusive parenting in the past and rigid and punitive parenting in her foster home. Certainly I question if transference issues were exaggerated because her mother, foster mother and I were all similar-aged females. Annie's generally bossy, controlling behaviour, and often angry and aggressive behaviour, suggested that she had come to expect her caregivers to let her down or act negatively towards her. Because of this, she viewed even benign or unintentional mishaps as aggressive.

Annie would become enraged at times if I looked at her in a way she did not like ("Quit staring at me!"), talked to her about seemingly neutral topics such as how her day had been ("Shut up!" "I'm not talking to you!" "I'm not listening!"), or performed a task in a way she did not like. On one occasion, she yelled, "You're mean!" when I failed to draw shoes on a picture of a woman in the way she wanted me to. On another occasion,

she insisted that I had spilled paint on her pants when I had not. My own feelings of surprise, confusion, anger, fear and frustration elicited at times by Annie's outbursts afforded me insight into her chaotic and emotionally disorganized world. However, I believe, transference issues also hampered the development of a positive therapeutic relationship, slowing down the potential shift in Annie's inner working models and negative worldview, and subsequently, slowing down her ability to address maladaptive behaviours.

Transference issues were also apparent with Curtis who initially, I believe, felt a need to be "good" and not disappoint me as he felt he had disappointed his mother. This, from Curtis' perspective, had resulted in his mother abandoning him. During early play therapy sessions, Curtis was unfailingly polite, cheerful and cooperative. On several occasions, he made up a game in which characters were required to be good. If they failed to be good, Curtis would burst a balloon that he referred to as "the balloon of death" as a means of punishment.

During Curtis' 17th play therapy session, he took a Beanie Baby from the playroom without permission, telling his foster parents that I had given it to him. The foster parents later called me to verify this as Curtis had produced the Beanie Baby long after he and his foster family had already left the play therapy session. When Curtis returned the following week, in contrast to eagerly meeting me and heading straight for the playroom, he remained seated and did not make eye contact with me. With some prompting from the foster mother, he flatly apologized and returned the Beanie Baby.

I interpreted Curtis' behaviour around this incident as revealing several different feelings, needs and desires. On one level, I believe that Curtis really liked the Beanie

Baby and had, on impulse, taken it home with him. I thought it was interesting, however, that given his general preoccupation with toys associated with aggressive play, he chose to take a soft stuffed animal. This seemed to me a symbol of his need and desire for nurturing as well as perhaps feelings of attachment to me as his therapist. His behaviour upon being found out conveyed feelings of shame and fear of rejection. On this occasion, I tried to reassure him that I was not angry and that there was nothing he could do that would make me not like him or want to see him.

Eight weeks later, after considerable deliberation, I gave Curtis a different Beanie Baby for Christmas – a dog whose purpose, according to his accompanying poem, was to protect and look after his owner. I deliberated about this decision, as I did not want to reinforce stealing behaviour by rewarding it. However, I decided to address the underlying needs expressed by Curtis' actions on this occasion.

Curtis was thrilled with his present and had me read the poem to him several times. During several later sessions, he brought the Beanie Baby with him and demonstrated how he groomed and bathed it. He noted happily how the dog enjoyed being with him and making sure he was okay.

In this manner, he confirmed for me my original hypothesis about the stealing behaviour. My non-punitive and nurturing response allowed him to realize that he could make mistakes (i.e., behave badly sometimes) and still get his needs met. Since that time, he has not (to my knowledge!) taken anything from the playroom without permission. Yet another Beanie Baby played a prominent role in subsequent play therapy sessions. This will be discussed in a later section.

In summary, transference issues may hinder the development of a positive therapeutic relationship. However, transference issues can also be helpful during both the assessment and treatment phases of play therapy, providing invaluable insight into a child's perception of his or her environment and indicating appropriate points of intervention. Recognition of transference issues can also be helpful during the termination phase of therapy in attuning a therapist to sensitive issues of loss and grief for a child. Recognition of one's own countertransference issues is equally important in avoiding biased or inaccurate assessment of children's needs.

Loyalty to Parents

Children frequently demonstrate strong feelings of loyalty towards their parents, whether they live with them, live with alternate caregivers or have never met their parents. Children's feelings about their parents – good and bad – need to be treated with respect and sensitivity. It can be especially difficult for alternate caregivers to witness and understand children's loyalty towards parents who have harmed them, and their pain and subsequent acting out behaviour upon separation from them.

Steinhauer (1991) notes that what they fail to recognize is that children's continued identification with the birth parents results in their interpretation of criticism of them as an attack on themselves. He continues:

> Such criticism, especially when repeated, not only undermines the child's relationship with the foster parents but, by intensifying her relationship with the natural parents, further deflates her self-image by reinforcing her feeling of being bad, immoral, or otherwise unworthy, like her parents. (p. 161)

As Lee and Nisivoccia (1989) gently suggest to foster parents:

> If you are doing a proper job of parenting a foster child, the great bulk of his needs is being met by you. But he has one need you cannot meet – he needs to be able to love his parents. This works out differently at different ages, but the need is never absent. You hope his need is met eventually by a corresponding need of his parents to love him, and you do all you can to foster and strengthen love between them. (pp. 61-62)

Mann and McDermott (1983) observe that early on in treatment, therapists, too, tend to overidentify with the child especially if there has been little or no contact with the parents. They further note that therapists may struggle with anger and other negative feelings towards the parents for having mistreated the child as well as feelings of hopelessness for not being able to "fix" the situation adequately.

Because I have worked with children and families for approximately 12 years and was aware of these issues, I did not think I would experience these feelings. I did, however, find myself struggling at points along the way. At these times, regular supervision and case discussion with colleagues was invaluable in allowing me to vent my feelings and "recognize the limitations of therapist involvement in the overall treatment of abused children and their families" (Mann & McDermott, 1983, p. 304).

Being aware of these issues also helped me guide Lenny's aunt and Tracy's foster parents in dealing with the feelings of their children as well as their own feelings about the children's birth parents. This part of the intervention process with Lenny's aunt was

discussed previously. Tracy's foster parents reported that she rarely spoke about her birth mother who frequently did not show up for scheduled visits. Tracy's general response both at home and during play therapy sessions was to state that she did not care, that she did not think about her birth mother and to deny feeling hurt or angry by her birth mother's actions.

I initially interpreted Tracy's behaviour as a defense strategy for avoiding difficult feelings of loss, anger and hurt. However, as play therapy progressed and we continued to talk about her family, Tracy's affect was so consistently matter-of fact that I began to question if this was the case at all. Given that other family members primarily raised her, I began to speculate that she perhaps did not have an attachment, healthy or otherwise, to her birth mother and explored the possibility of other attachment figures in her life.

When discussing family of origin issues during play therapy sessions, Tracy eventually developed stronger affect when denying feelings about her birth mother missing visits. This confirmed my original hypothesis. I was then able to offer guidance to Tracy's foster parents again based on Fraiberg, Adelson, and Shapiro's (1980) Ghosts in the Nursery. Suggestions included talking to Tracey about her family, letting her show her foster family pictures of her birth family and not expressing their own anger at the birth mother on the occasions when she did not show up for a visit.

An awareness of loyalty issues in children towards their parents was also beneficial in being able to advocate for Annie around contact with her mother after she was made a permanent ward of the agency. The original decision to terminate contact was made without consulting me and, I suspect, partially because of input from Annie's foster parents who reported acting out behaviour after visits, and from the support

worker who supervised the visits. Steinhauer (1991) notes that "foster parents often vigorously oppose the continued involvement of natural parents, claiming that access to the natural family upsets the child and disrupts the foster family, which must live with the child's response to the visit (p. 159).

During visits, Annie was observed to be highly punitive and controlling towards her birth mother. According to Steinhauer (1991), this behaviour is commonly observed in children at age six who were categorized as Disorganized/Disoriented infants (Main & Hesse, 1990). Children's behaviour in this category can be linked to their responses to frightened or frightening behaviour of their caregivers. Agency personnel and Annie's foster parents interpreted Annie's behaviour as disliking her mother and not wanting to see her.

In my opinion, Annie's feelings were considerably more complex than this as demonstrated by her metaphorical play during play therapy sessions. As Provence (1987) notes, "Many children are strongly attached to parents who abuse them, and even though they may show relief and begin to thrive when placed with adults who provide protection and better care, they may nonetheless feel the loss deeply and show separation anxiety" (p. 97). Because contact was terminated and long-term placement planning was uncertain, I did not advocate to have visits resumed immediately but instead advocated for Annie and her birth mother to be able to contact one another by letter, pending permanency planning and further assessment.

In summary, children who have been abused or neglected frequently exhibit overwhelming loyalty to those that hurt or neglected them sometimes at the expense of positive feelings about themselves or others that care about them. Simultaneously

identifying with their parents, they often view criticism of their parents as criticism of themselves. Loyalty to parents and frequently the subsequent idealization of parents, is often an illustration of children attempting to protect themselves from the reality that people who were supposed to love and take care of them were unable to do so as demonstrated either by acts of omission or commission. It is important that children's feelings about their parents, no matter what the history or quality of attachment, be respected by play therapists and other members of their treatment teams. It has been my experience that therapists and other treatment team members need to recognize and honour children's positive feelings about their parents before children may feel safe enough to enable them to address the more painful aspects of the parent-child relationship.

Emotional Issues: Anger, Anxiety and Aggression

Feelings of anger, anxiety, aggression, and separation/loss have a complicated inter-relatedness and are frequently found in a population of maltreated children. They were most certainly present - not necessarily overtly - in one form or another with all of the children I saw for play therapy during this practicum process.

Bloom-Feshbach and Bloom-Feshbach (1987) describe anger as a "subjective state of distance from others" in that "the lack of closeness experienced during anger is itself a separation experience" (p. 44). Thus they maintain that in addition to separation and loss evoking feelings of anger, "the angry state itself intrinsically involves additional feelings of loss (which produce more anger, implying more distance and hence more anger, and so on)" (p. 44). They continue:

> In this way an intense cycle of feelings of separation and anger builds to a climax of heightened rage that may be too threatening to be consciously experienced or expressed, especially when the scales tip in the direction of separation and loss rather than closeness and nurturance. When rage cannot be expressed, it becomes hidden and transformed, most often into depression and frequently from depression into anxiety or psychosomatic complaints ... (p. 44)

Steinhauer (1991) writes that while "disturbed and conflicted family experiences both prior to and following separation contribute greatly to the rage so prominent in many (foster) children (who have been maltreated)", children's reaction to real or perceived abandonment can also generate significant feelings of rage (p. 35). He notes that for children

> who have difficulty controlling their feelings, the cumulative rage, its expression blocked and distorted by the defences developed against it, may become dammed up, repressed, generalized, diffused, and displaced. This process stresses the developing personality, undermines and destroys potential relationships, and can dominate both mood and behaviour. Anger ... can be internalized and turned against the self, in which case it will contribute to the depression commonly seen in such children. (pp. 35-36)

Unfortunately, it would seem that maltreated children's feelings of anxiety and anger evoked by living in an unsafe home environment, as well as their sometimes aggressive behaviour, are not necessarily alleviated by out-of-home placements. They may, in fact, be exacerbated by issues of separation and loss if they are not addressed. In my experience and because of this, issues connected with the out-of-home placement need to be addressed in play therapy first or, at times, concurrently, with family of origin issues.

Annie and Lenny's behaviour in relationship to feelings of anger, anxiety, aggression and separation/loss have been discussed previously. Regarding Curtis, his mother described his behaviour towards her as extremely aggressive before he entered foster care. Agency workers involved with the family at the time attributed Curtis' original aggression to anxiety, anger and frustration stemming from his mother's emotionally detached way of parenting him as well as to her age-inappropriate and unrealistic expectations of him.

Unable to respond to Curtis' need to please her and feel closer to her, his mother's frequent response to his anger was to send him to his room at which point, he would become enraged. As Greenspan and Greenspan (1985) note, "(Sending a child to his room) may give a child the sense that his anger will always lead to separation. Under these circumstances he may find his anger even more frightening than it was initially" (p. 203). Sadly, in Curtis' case, his mother eventually placed him in care when she was no longer able to manage his aggression, prolonging the separation and its attendant feelings of anxiety for Curtis.

Curtis appeared to blame himself or others for being separated from his mother. He was initially unable to express any anger towards her and, indeed, seemed to idealize her (see Loyalty to Parent's theme). As a result, early therapeutic intervention needed to be directed at helping Curtis cope with his feelings about the separation and his out-of-home placement, his cognitive distortions about himself and his situation, and his difficult behaviour. Only later in therapy sessions was he able to tolerate, in a limited manner, discussion of abusive incidents prior to coming into care and some of his negative feelings about his mother.

In care, Curtis continued to experience Provence's (1987) intense cycle of feelings of separation and anger resulting in additional feelings of "badness", shame and anxiety. His feelings of anxiety were heightened by his perception that he could not return to his mother until he no longer acted aggressively. Curtis' anxiety and anger was further exacerbated by the reason provided by his mother for not previously visiting him very often. Curtis reported his mother telling him it was her wish he "get his behaviour under control" before she started visiting him more frequently.

At school and in the foster home, Curtis often used intimidation and bullying of younger and smaller children to feel more in control without always using overtly violent behaviour. Because he frequently perceived his rage as too threatening and overwhelming, Curtis also sometimes turned it inwards, resulting in feelings of pervasive sadness, "sneaky" behaviour such as stealing and lying and, at times, explosions of violent temper when he was no longer able to defend against it.

Curtis' behaviour can be interpreted as both originating in and being maintained by extreme separation anxiety. In the playroom, Curtis' feelings of anger were

consistently demonstrated by his aggressive themes of play. Weeks of play therapy sessions would entail elaborate battle scenes in which Curtis always won. "Sneaky" behaviour such as trying to take extra candy or cookies, attempting to steal from the corner store on outings and pretending to break toys by accident were aiso demonstrated. Overt displays of aggression were rare. On one occasion, Curtis deliberately smashed a dollhouse after being told this was not allowed. Curtis' response was to try and reengage me in play immediately.

This incident occurred during a period of high stress for Curtis that seemed to be related to his difficulty adjusting to differing rules between his foster parents' and his parents' households. His foster parents and parents had also observed acting out behaviour during this time. Shortly after this incident, Curtis asked to borrow a book from my book collection. I decided to allow this, not only as a demonstration of my trust and regard for Curtis, but as a means of increasing feelings of connectedness for him while he remained "in limbo' between the two households.

After a bumpy start of having to remind Curtis to return the book, borrowing two books per session became part of our routine. Each week, Curtis returned the books he borrowed the previous week and chose two others. It became a matter of pride for him to return the books before being asked. On the odd occasion that he forgot one or both books, he always promised to bring them the following week and reminded himself aloud that he could not borrow another one until the others had been returned.

At the end of our 47th session, Curtis, who had brought a Beanie Baby with him that he had received as a present from his parents, told me that he was going to leave him with me to look after for the week. I interpreted Curtis' actions on this occasion as a

touching illustration of his ongoing need for nurturance and connectedness with important people in his life as well as possibly a need for connection among all the people who cared about him.

Issues of anxiety, anger, aggression and loss during play therapy sessions with Tracy were less overt but still present, as she appeared to be actively defending against them using simple coping mechanisms such as avoidance and denial. Her feelings were revealed indirectly. For example, feelings of anxiety were suggested by her refusal to enter the playroom before I did and references in play to dolls needing to be safe. Feelings of anger and aggression were alluded to in a playful manner at times when she discussed her interaction with peers at school. Feelings about separation and loss from her family of origin have been discussed previously when discussing the importance of the therapeutic relationship.

As a novice play therapist, I attempted to be particularly aware of how my own anxiety about the learning process impacted on the children's generalized anxiety. I had concerns, too, about my ability to deal with the children's potential to be physically aggressive in the playroom when experiencing angry or anxious feelings. The research and literature on the physical expression of aggression as a means of catharsis remains mixed with some writers viewing it as a healthy means of reducing aggressive impulses and others viewing it as a means of reinforcing aggressive impulses (Schaefer, 1993, pp. 109-114, 133-134).

Schaefer (1993) suggests that in dealing with aggressive behaviour in play therapy, "the introduction of a few specific limits combined with a systematic way of helping children be responsible for them establishes the security of (the play therapy)

environment" and "helps the children to accept their own feelings and thereby be more readily able to achieve mastery over the interruptions in their efforts to develop themselves within a social and interpersonal context" (pp. 134-135). He adds that the safety and security of this environment enables children to express and release emotions unacceptable elsewhere in their lives.

I soon discovered that the children's feelings of anger, anxiety and separation/loss were frequently limited to metaphorical play, providing distance for both them and me. I was relieved to discover that even Annie's temper tantrums were manageable. At times, however, limit setting and redirection were necessary in curtailing Curtis' aggressive play when his affect and behaviour escalated in a manner that appeared to be reinforcing his aggressive impulses.

In summary, it is apparent that therapists dealing with this population of children need to be prepared to deal with intense and difficult feelings of anger, anxiety, aggression, and separation/loss that adults often find unacceptable in children. It is part of the therapeutic process to address and process these feelings with children in order to re-establish a healthy pattern of emotional, cognitive and social development. Therapists also need to be prepared to deal with those feelings elicited in themselves by the children's behaviour and circumstances.

Developmental Issues

One of my learning objectives was to develop a better understanding of normative childhood behaviour and childhood behaviour that should be cause for concern. I especially wanted to feel more confident in assessing children's sexualized behaviour in

this regard. Research by Friedrich (1990, 1991), Gil and Johnson (1993) and Johnson (1996) about children's sexual behaviours was particularly helpful.

Knowledge of developmental issues is important during the assessment component and goal setting component of play therapy in order to identify if a child is deviating from developmental norms and, if so, in what way. In addressing any issues in play therapy, therapists need to be aware of developmental levels in order to ascertain appropriate means of intervening. Premature attempts at changing distorted perceptions about family members may be futile, for example, if a child's conceptualization capacity is not sufficiently developed. Harter (1983) notes that very young children do not understand that two feelings can occur simultaneously. As children mature, they develop an understanding that two feelings can be experienced sequentially, two compatible feelings can be experienced simultaneously and eventually, that one or more incompatible feelings about the same person or thing can be experienced simultaneously.

In working with four-year-old Lenny, for example, it was apparent that he was able to feel sadness or anger about his absent mother but not usually at the same time. He was certainly not able to identify positive feelings about her when experiencing sadness or anger. Lenny's developmental level guided me in my treatment goals away from excessive verbal exploration of feelings and towards addressing Lenny's needs for nurturing, attention, safety and predictability in his present home environment.

It is also helpful if therapists are aware of a child's developmental stage at the time of a known trauma or separation and loss. In this way, distortions in subsequent development can be understood and addressed. Unfortunately, all of the children seen for play therapy during this practicum process experienced chronic trauma and neglect during

early childhood culminating in separation from primary caregivers upon coming into care. Because of these factors, it can be inferred that they are at risk for experiencing distortions in basic personality and identity development including deficits in their attachment capacity (Delaney, 1991; Steinhauer, 1991), issues around trust, and feelings of shame, doubt and guilt (Erickson, 1980).

My increasing knowledge of normative child behaviour, sexual and otherwise, was also helpful in assisting caregivers such as Lenny's aunt put their children's behaviour in a developmental context. She could be reassured, for example, that Lenny's desire to do things for himself, his lying, and his difficulty taking responsibility for his actions were all typical behaviour for a child his age. Lenny's aunt also expressed concern that Lenny's frequent touching of his own genitals was an indication that he had been sexually abused. While I was unable to tell her categorically that Lenny had not been abused, I was able to let her know that his behaviour was normal for a child his age in developing a sense of himself and his environment. I also suggested that at stressful times, children sometimes soothe themselves in this manner.

Other areas of development about which therapists need to be both knowledgeable and sensitive include children's defenses and coping mechanisms in surviving an abusive or neglectful environment. Young children's behaviour is related to their dependence on adults for their physical and emotional well being. Behaviours in children who have been abused or neglected by their caregivers can be viewed as adaptive for the purposes of eliciting caregiving behaviour while simultaneously protecting themselves from harm often from the same person. This was evident in Annie's manipulativeness and need for control which engaged adults but on "her terms"; Lenny's

regression which invited nurturing behaviour, and his detached way of relating to others which kept him at a safe distance; Curtis' attempts to behave perfectly in order to be allowed to go home and not displease his mother; and Tracy's general denial of negative feelings to avoid provoking a negative response in adults.

In summary, knowledge of developmental issues is an essential part of play therapy with children in terms of appropriate assessment, goal formulation, points of intervention, education and support for caregivers, and understanding of children's defenses and coping mechanisms.

Systemic Issues

It is especially important to intervene at a systemic level when working with child maltreatment as it recognizes the importance of various systems on a child's functioning and sense of identity. At the start of this practicum process, I was already aware of systemic issues that can have a negative impact on the care children at risk receive: a shortage of high quality foster care providers, child welfare workers with heavy caseloads, long, drawn-out court procedures and recently, a trend (driven by financial and political forces) towards minimal interference in families and reunification of families where progress has not necessarily been demonstrated.

It is my opinion that play therapy in this context should not preclude attempts to obtain information from, and work, with all systems involved with a child regardless of the obstacles. Obtaining information from schools, foster parents, birth parents and agency workers provides a better understanding of the child within his or her various environments. Additionally, it provides a system of checks and balances in assessing the

need to intervene with aspects of the child's environment rather than just the child. This was poignantly demonstrated in terms of both Annie and Lenny's home environments.

Nor, however, should working systemically preclude advocating with various parts of the system for a child's needs to be better addressed. The need for advocacy in Annie's situation, for example, has been discussed previously. Another need for advocacy arose when Tracy's agency worker refused to make alternate arrangements for transportation to her play therapy sessions after the agency driver left the agency. He believed it was the foster parents' responsibility. The foster parents believed it was the agency's responsibility. The impasse between agency personnel and the foster parents resulted in Tracy missing four appointments in succession and her social worker reporting that therapy would simply have to be discontinued if the foster parents were not able to drive her. The impasse was eventually overcome through a mediation process in which the agency agreed to pay the foster parents' mileage to bring Tracy for her weekly appointments.

In summary, working systemically can be a particularly effective means of intervening with troubled children and their families. Despite the potential obstacles and the sometimes complex dynamics that arise, systemic intervention provides a broader perspective on children's functioning and the functioning of their caregivers. It also provides a system of checks and balances to ensure children's needs are being adequately met.

CONCLUDING REMARKS

In their review of the play therapy intervention literature, Landreth, Homeyer, Glover and Sweeney (1996) concluded that play therapy was considered mostly or completely successful with 80% of children in treatment. However, in reviewing the overall meager (but growing) accumulation of clinically related data and research, Phillips and Landreth (1998) caution that "the gains in specific and useful knowledge have been small" (p. 3). A recent survey of 1166 play therapists in the United States revealed that 80% of clients ended treatment "mostly successful" or "completely successful" (Phillips & Landreth, 1998, p. 8). The authors use these findings to encourage future rigorous and empirical evaluations of play therapy (Phillips & Landreth, 1998).

Interestingly, the play therapists interviewed for Phillips and Landreth's survey (1998) consistently cited play therapy as useful with a population of sexually or physically abused children (p. 11). According to the majority of therapists in the study, "Success in play therapy is determined largely by the relationship between therapist and child, as well as the involvement of parents/family in treatment" (Phillips & Landreth, 1998, p. 12). I agree with this.

My subjective impression of the play therapy process was very positive. I experienced play therapy as a dynamic and effective intervention with children who have been maltreated. If play is the language of children in general, it is most certainly the language of children who have been silenced by fear, pain and rejection. Giving voice to children through imaginary play, song or art can be both poignant and powerful as can giving tools to caregivers that complement their children's therapeutic work and allow them to meet their children's needs.

In terms of my learning goals for the practicum, I believe I was able to meet them all to varying degrees. However, in meeting the three general goals set for myself, more goals were generated. For example, I believe I gained experience using different long-term play therapy models and techniques with boys and girls at different developmental stages, and from different socioeconomic and cultural backgrounds. I would also like, however, to become proficient in providing short-term crisis-oriented play therapy for children and in conducting play therapy assessments for court purposes (Trubitt, 1994).

Additionally, because all of the children I saw were living in out-of home placements, I did not get an opportunity to work extensively with birth parents. I discovered during the practicum process that issues related to out-of-home placements generally took precedence over those more directly related to the maltreatment experienced by the children. I would like to gain further experience in providing play therapy for children residing with their birth parents with all the accompanying dynamics.

In learning about the many different types of play therapy, I also discovered play therapy models and techniques that require further specialized education and training. I would very much be interested in developing music therapy and Theraplay skills, for example, as well as the ability to conduct Filial Therapy sessions with parents and children. Interestingly, I first found myself appalled at suggested Theraplay techniques, viewing them as intrusive, controlling and disrespectful of a child's boundaries. However, I came to believe that some Theraplay techniques in the context of relationship-focused therapy could be very effective in encouraging attachment. My relatively small experience with them during this practicum underscored this for me.

In terms of my second goal of learning to communicate effectively with caregivers, I felt only partially successful. While my experiences with Curtis and Tracy's foster parents were positive and balanced, my experiences with Annie and Lenny's caregivers were somewhat frustrating. I would have preferred to have been able to develop a positive working alliance with Annie's foster parents. However, I believe that advocating for a change in placement was necessary when it became apparent that her foster parents were unable to provide for her special needs.

The decision to advocate for an alternate placement for a child or to notify Child and Family Services of parenting concerns needs to be based on a number of considerations. These include a child's safety and emotional needs, and attachment to his or her caregiver, the need to maintain the integrity of the therapeutic relationship, the caregiver's ability to benefit from additional support and education if available, and an appropriate interpretation of the Child and Family Services Act, which defines the conditions under which notification of a child welfare agency is mandatory.

Finally, I believe I gained valuable knowledge about normal and concerning child behaviour in the context of child abuse and neglect through my experiences with the four lovely children who participated in play therapy, their caregivers and other collaterals such as school and daycare personnel; regular supervision; and ongoing review of the available literature. Since the literature is always being updated, I can only hope to keep up with current trends in clinical and empirical findings.

One of my final goals generated by the completion of this practicum process is to conduct future research on the various facets of play therapy. Selected research topics I have considered include its general efficacy, the role of the person who provides

transportation for children to play therapy sessions, and a longitudinal study of children seen for play therapy.

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APPENDIX

Customer Satisfaction Questionnaire

I would like to know your thoughts and feelings about coming to the Elizabeth Hill Counselling Centre.

1) What was good about coming to the Elizabeth Hill Counselling Centre?

2) What was not so good about coming to the Elizabeth Hill Counselling Centre?

3) What did you learn from coming to the Elizabeth Hill Counselling Centre?

4) If things could have been different about coming to the Elizabeth Hill Counselling Centre, how would you have changed them?

5) Is there anything else you would like to say about coming to the Elizabeth Hill Counselling Centre?