Play Therapy With a 6-Year-Old

SYNOPSIS OF THERAPY APPROACH

Psychoanalytic play therapy is based on an assumption that children's problems stem from unconscious conflicts and developmental deficits that will reveal themselves in their play. Through their play, their verbalizations, and their relationship to the therapist, children can be helped to understand what is troubling them. A child's behavior (problematic or not) is taken to be an attempt at meaningful communication of underlying thoughts and feelings, and, through therapeutic understanding of the child's communications, resolution of problem behaviors can occur.

Psychoanalytic play therapy includes the involvement of the child's parents. The therapist's familiarity with the child's parents helps the child feel accurately understood (which facilitates the resolution of the child's difficulties). Furthermore, this involvement provides parents with practical strategies for managing problematic behaviors at home. Symptoms can then improve and troublesome behaviors diminish in frequency and intensity. In addition to working with parents, child therapists often coordinate with schoolteachers and counselors to help resolve any behavioral difficulties at school and increase understanding of the child's emotional issues.

In psychoanalytic play therapy, the child takes the lead in producing "material" in the form of play. It is a nondirective approach in which the therapist follows the child and not vice versa. When the therapist is careful to avoid giving advice or making suggestions, the child becomes increasingly able to reveal his or her emotional life in spontaneous play. The therapist attempts to understand what the child is communicating through his or her play (i.e., what the child is thinking and feeling, both consciously and unconsciously). As the child plays, the therapist comments on the play itself, its underlying (latent) meaning, and its relation to presenting symptomatology.

Play therapy is generally conducted on a once or twice weekly basis, in 50-minute sessions. The child's therapist (or an adjunctive therapist working with the parents) usually sees the parents on a regular basis ranging from once weekly to once monthly. Play therapy should be conducted in an appropriately equipped room such as a playroom. The length of treatment may vary, from as brief as 6 months (minor adjustment problems) to as long as 4 years (depending on a variety of factors including severity of pathology).

Sometimes therapists are uncertain about how to act and "be with" a young patient. Children respond best to therapists who can be themselves comfortably, who are at ease with play, and who are neither overly solicitous, nor condescending. The therapist's task is to invite the child, through a calm demeanor and willingness to understand, to unfold his or her concerns in play and talk.

FOR WHOM IS PLAY THERAPY INDICATED?

Play therapy is recommended for children between the ages of 3 and 11 who present a wide variety of emotionally based difficulties. These include problems relating to peers, problems with appropriate expression of anger, childhood depression, anxiety, adjustment reactions to specific life events, school difficulties that have an emotional component, deficits in self-esteem, persistent withdrawal, more severe character pathology, attention-deficit disorders, development disorders, and symptoms inappropriate to the youngster's current age (such as enuresis and encopresis). When a child experiences any of these difficulties to such an extent that symptoms are pronounced, recurrent, or continual, treatment may well be indicated.

The following factors are considered when determining whether or not treatment is indicated:

- how long the problem has persisted
- if the problem is interfering with family life
- if the child is experiencing significant internal distress, even though overt symptoms may be subtle
- if attempts have been made in the past to help the child overcome the problem
- how disruptive the problem is to the child's daily functioning
- if the problem is interfering with academic performance
- if the problem is interfering with normal maturation
- if the problem is unusual for the child's developmental stage
- if the problem is actually embedded in a pattern of symptoms (Nemiroff & Annunziata, 1990).

WHAT RESOURCES MUST THE CHILD POSSESS TO UNDERTAKE PLAY THERAPY?

For play therapy to be helpful, it is essential that the child have sufficient intellectual endowment. Play therapy has been meaningfully conducted with mildly mentally retarded children as well as with exceptionally bright children. The child must also have some capacity to form a relationship with a helping adult. In addition, at least a rudimentary observing ego should be present. *Observing ego* refers to the child's capacity for self-reflection and for claiming one's own behaviors, thoughts, and feelings rather than simply being told about them by the therapist. This is important because in psychoanalytic therapy, the goal is to try to understand the origins of problems in internalized conflict. The first step in this process is to be able to observe one's internal and external self.

The idea of symptoms residing in internalized conflict can be confusing as therapists struggle with the question of whether the problems are truly internal or are imposed on the child by the environment. Child therapists generally find that specific environmental events certainly impinge on a child's development and can contribute to the development of symptomatology. However, children then may respond to this stress with an internalized reaction and an adaptation that fosters and entrenches this symptomatology. For example, a 5-year-old girl becomes distressed by the birth of a sibling. She has not learned to tolerate her angry feelings and thus guiltily inhibits them. She begins to wet her bed nightly, much to her shame. Psychoanalytic play therapy addresses her conflict regarding the expression of aggression and helps her come to understand her bed wetting as a compromise (i.e., compromise formation) between direct expression of sibling rivalry ("unacceptable" aggression), guilt about her aggression, and fear that she will disappoint her parents and thus lose their love if she should express her anger toward the sibling. The bed wetting, then, represents a neurotic symptom, born of conflict. This example also demonstrates the importance of working with both symptomatic children and their parents. The parents, in coming to understand what ails their child, can respond to her distress in ways that will facilitate her therapeutic progress.

Some children, on the other hand, *are* primarily responding to a dysfunctional family system, without evidence of internalized conflict. Family therapy should be considered as the possible treatment of choice in this situation.

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Dr. Annunziata identifies her approach as "play therapy." What does this imply to you? More specifically, what do you expect of her? Will Dr. Annunziata be active or passive? Will the session be structured or unstructured? Directive or nondirective? Will it focus on the past or on the present? Will the session focus on behaviors, on thoughts, or on feelings? What do you expect to be the relative balance between attention to technique versus the interpersonal interaction?

CLIENT BACKGROUND AND PRECIPITATING EVENTS

■ Matthew ■ Age: 6 years old ■ Sex: Male ■ Race: African American ■ Education: Currently attends first grade ■ Parents: Mother, living; Father died when Matthew was 4 years old ■ Mother's education: Master's of Business Administration ■ No siblings.

Since his father's death, Matthew has been intermittently sad and withdrawn. He has been behaving in an increasingly protective way with his mother, and he feels more responsible for her as he has gotten older. He frequently tries to "cheer her up" and make her happy.

Matthew doesn't talk much about missing his dad, his dad's death, or his feelings in general. When asked about his feelings about his father's death, he minimizes the impact and tends to find a bright side to it, saying, for example, "I have such a nice mom, and I have lots of nice cousins and uncles."

He presents for treatment because his mother often finds him waking with bad dreams, sobbing. She also reports periodic instances of sadness during the day and withdrawal from family and peers. His teacher reports that on occasion Matthew does not want to go out for recess, and he looks sad at those times. His teacher also notes that he is withdrawing from classmates more frequently and participates less actively than before in classroom activities.

Matthew's mother has not dated since her husband's death 2 years ago. She appears somewhat sad and is frequently tearful, although she is not

clinically depressed. She reports that she enjoys her work as a bank executive and that she has a strong network of friends and family.

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What is your impression of Matthew? How typical or atypical are his life experiences and his current behavior?

What do you believe are the core issues for Matthew? What is the utility of these initial formulations?

Before reading the next section, what topics and issues do you think will be addressed in the next phase of therapy?

Process Notes on Initial Sessions

Seven sessions preceded the videotaped session. These included one background and one child guidance session with the mother, two play evaluation sessions with Matthew, and three play therapy sessions with Matthew.

Sessions 1 and 2 *(initial evaluation for background information with mother)*: In these 1-hour sessions, Dr. Annunziata asked Matthew's mother to provide identifying data including his name, age, family constellation, and living arrangement. She described his presenting problems—awakening with bad dreams, sobbing, periodic sadness and withdrawal; their onset, history, severity, and frequency; her attitude about the problems; and the effect the problems have on his schoolwork. His mother also provided a detailed developmental history that included conception, pregnancy, feeding, sleeping, motor development, toilet training, play patterns, emotional and physical health history, school history, relationships, separations from parent(s), expressions of aggression, and style of parental discipline at home.

During these initial sessions with the mother, Dr. Annunziata talked with her to get a detailed picture of the family: description and significance of the family's economic situation; their social, ethnic, and religious ties; the nature of interrelationships in the family; the quality of the marriage; and Matthew's mother's reaction and Matthew's reaction to her husband's death. Matthew's mother also described her past history (i.e., her significant life experiences) as well as her deceased husband's history.

Sessions 3 and 4 *(assessment of Matthew)*: In these two sessions, Dr. Annunziata observed Matthew's play, his general behavior, and his verbal communications to evaluate his affect and mood, his conscious and unconscious conflicts and concerns, his cognitive functioning, his defensive structure, his perceptions of himself and family members, his capacity for relatedness to her and others, his developmental appropriateness, and his stream of speech and other physical activity. She also assessed the quality and type of his play activities as well as his apparent motivation for treatment and attitude toward receiving therapeutic help.

Sessions 5 through 7 *(play therapy sessions)*: In the first 50-minute play session, "Dr. Jane" (as she tells Matthew he can call her) introduces Matthew to the playroom. She shows him the various toys, and tells him the three basic rules:

a) During play nothing should be broken on purpose,

b) no one should be hurt, and

c) he needs to clean up the playroom with her at the end of their session.

Dr. Jane asks Matthew, "Do you know why you are here?" Matthew tells her that he thinks it is because his mom is worried because she thinks he is sad. Dr. Jane responds, "Yes, you're right. Your mom is concerned because you've seemed sad. We are going to meet here today, and once every week for 50 minutes, to play and talk about your sad feelings and anything else that is worrying you or bothering you."

She continues by telling Matthew about confidentiality: "Everything we talk about is private and a 'one-way secret.' That means you can tell anybody anything you want to about our sessions, but I won't talk about them to anyone else. I will meet with your mom about one time each month to give her a general idea of what we're working on, but I will not tell her about the specific things that we talk about or do here. Also, if you ever tell about