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Play Therapy: Practitioners' Perspectives on Implementation and Effectiveness

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Play Therapy: Practitioners' Perspectives on Implementation and Effectiveness

by
Jade E. Wageman, B.S.

MSW Clinical Research Report

Presented to the Faculty of the
School of Social Work
St. Catherine University and University of St. Thomas St. Paul, Minnesota
in Partial fulfillment of the Requirements for the Degree of
Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

The purpose of the present research was to explore practitioners' perspectives on play therapy as an intervention when working with a child who has experienced trauma, has present PTSD symptoms and has a co-morbid mental health diagnosis. Play therapy has been accepted as an effective intervention to utilize with children who have been exposed to trauma (Schaefer, 1994). However, there is currently limited research evaluating play therapy as an intervention with children who have been traumatized and have developed PTSD or other mental health symptoms/disorders. The current study aimed to supplement the gap in existing research. Two agencies that serve early childhood mental health clients agreed to participate in the present study by completing an online survey. Data was gathered from 22 practitioner respondents. The results indicate that practitioners believe that play therapy is an effective intervention when treating children with trauma histories, PTSD symptoms, and mental health disorders. The results of the present research support findings from previous literature regarding play therapy when used as an intervention for treating trauma and/or mental health disorders. Furthermore, the present research confirms the notion that creating a safe space for their clients using play therapy is an important part of the intervention process. Given the gap in research surrounding play therapy as an intervention when PTSD and a co-morbid mental health disorders occur concurrently, further research would be beneficial to the field of social work and would positively inform the practitioners who work in early intervention settings.

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Play Therapy: Practitioners' Perspectives on Implementation and Effectiveness

Trauma is a complex experience that once exposed to, has the ability to change the trajectory of one's life (Cook et al., 2005; Moroz, 2005; Terr, 2003). The occurrence of trauma in the life of a child adds a layer of complexity. The development of symptoms after a traumatic event can lead to the diagnosis of a mental health disorder, such as Posttraumatic Stress Disorder (PTSD) (Perry, Pollard, Blakley, Baker, & Viglante, 1995; Hamblen & Barnett, 2012). Children may also be diagnosed with other disorders dependent on their presenting symptoms. The prevalence of co-morbid mental health disorders when trauma symptoms are present is increasing in children (Terr, 2003). Finding an intervention that is developmentally appropriate for the traumatized child may prove difficult. This search is further complicated by the requirement of the intervention to address trauma resolution, symptom reduction, and skill development. Play therapy is an effective intervention in treating children exposed to trauma (Gil, 1991; Schaefer, 1994).

One can experience different forms of trauma. These forms of trauma could be physical, emotional, or psychological. Traumatic experiences are most often the consequence of a stressful event that makes the victim feel helpless and vulnerable. A situation does not need to involve the threat of one's life or physical harm to be traumatic. The subjective experience of the individual and the emotions elicited as a result are more important than the objective details when determining whether or not an event was traumatic to a particular individual. In most cases, the more afraid, shocked, upset, vulnerable and helpless one feels, the more traumatic the experience is for them (Robinson, Smith, & Segal, 2013). Specific segments of the general population are more vulnerable than others to experiencing trauma. Children make up one of these segments, as

they rely on their caregiver to meet their needs. In the United States, the reported rate of children's trauma exposure is startling.

Across the United States in 2011, 3.4 million referrals were made to Child Protective Services (CPS). Referrals were estimated to have included 6.2 million children, as in most states a referral can include more than one child. Once a referral is made, CPS conducts an investigation to determine the validity of the reported alleged maltreatment. Of the 3.4 million referrals made, 19% of the reports were substantiated and some variation of abuse or neglect was found. The Children's Bureau estimates that 681,000 children were victims of child maltreatment in 2011 (Children's Bureau, 2011).

Children who are victims of maltreatment and who may be exposed to other traumas are at an increased risk for severe developmental difficulties and delays. These deficits span across all areas of development, which encompass physical, psychological, cognitive, emotional, and social areas (van der Kolk, 2005). These developmental impairments and unresolved trauma experiences lead children to be faced with symptoms that may potentially result in the diagnosis of a variety of disorders. One of these disorders is PTSD, which may develop after the exposure to a traumatic event in which the child feels a threat to their personal safety or the safety of their caregiver (American Psychiatric Association, 2000).

Numerous research studies present findings indicating a strong correlation between PTSD and co-morbid diagnoses in children who have experienced trauma. Study results provide evidence that the presence of PTSD leads to the formal diagnosis of other mental health disorders. An array of mental health diagnoses have been reported to have a significant correlation to PTSD and are concurrently diagnosed. Some of these disorders include but are not limited to: attention deficit hyperactivity, anxiety disorders (panic, phobic, overanxious, simply

phobia, separation anxiety), mood disorders (major depressive, dysthymic), behavioral disorders (conduct, obsessive-compulsive), major affective disorder, adjustment disorder, dissociative disorder, and brief psychotic disorder/psychotic disorder NOS (Copeland, Keeler, Angold, & Costello, 2007; Cozolino, 2002; Famularo, Fenton, Kinsherff, & Augustyn, 1996; Lieberman, Chu, Van Horn, & Harris, 2011; Terr, 2003).

When looking at children, the age group of birth to five have been found to be the most vulnerable to experience trauma or be maltreated; yet, they remain the age group that is most underrepresented in research, policies, and clinical implications (Lieberman, Chu, Van Horn, & Harris, 2011). One way to remedy this deficit is to conduct research focused on interventions that are appropriate for treating PTSD symptoms and the present symptoms from the co-morbid disorder. Professionals who treat children that have been exposed to trauma need to be keenly aware of all of the symptoms the child is exhibiting. The treatment implications for this population are one of grave importance. By assessing, diagnosing, and treating children who have trauma symptoms, PTSD symptoms, a comorbid mental health diagnosis or any combination of these, children will be able to start a path toward resolution and healing (Famularo et al., 1996). Without proper treatment and resolution of their trauma, children are at risk for the development of mental health disorders.

Interventions that attend to severe symptomology assist in the resolution of symptoms and frameworks of trauma. Those promoting healthy relationships with caregivers should be considered by professionals in order to combat the rising trend of preschool children having mental health diagnoses and trauma exposure (Lavigne et al., 1996). Play therapy, when implemented in a preschool population, has the ability to reduce or resolve a number of common problems (Schaefer, 1994). LeBlanc and Richie (2001) also assert that play therapy has allowed

for significant positive changes in the behavior of children.

The Association for Play Therapy (2013) defines play therapy as "the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development". As the definition states, the main goal of play therapy is to prevent and resolve psychosocial issues in childhood, which is crucial to the proper development of the child. Through play and in a play therapy setting, children are able to learn about their worlds. They can interact with the therapist, their caregivers, and other children in a positive way, while simultaneously mastering challenges and using their creative thinking abilities (Landreth, 2002).

Landreth (2002) reports that play therapy is an effective intervention with children of all diagnostic categories; meaning that there are only very limited times in which one would caution providing children play therapy. Play therapy has been accepted as an effective intervention to utilize with children who have been exposed to trauma (Schaefer, 1994). Currently, there is limited research evaluating play therapy as an intervention with children who have been traumatized and have developed PTSD or other mental health symptoms/disorders. One study compared medical and nonmedical professionals preferred modalities when treating children with PTSD. Nonmedical professionals reported that nondirective play therapy was in the top three of preferred and most used modalities (Cohen, Mannarino, Rogal, 2001). However, there is a need for more research in this area.

The goal of this paper is to explore practitioner's perspectives on play therapy as an intervention when working with a child who has experienced trauma, has present PTSD symptoms and has a co-morbid mental health diagnosis.

Literature Review

The following review of literature will address trauma and corresponding effects on children, PTSD, and other disorders associated with trauma. Play therapy and its benefits will be discussed broadly as well as applied specifically to trauma and PTSD.

Trauma

All over the world there are billions of children who are exposed to traumatic experiences. Trauma is defined as a threat or assault that could be physical or psychological that impacts a child's safety, survival, sense of self, or physical integrity. This could also extend to the physical safety of a person who is significant to the child, most frequently their caregivers (American Psychiatric Association, 2000). Children can experience trauma due to varying circumstances. Some examples include abuse, e.g., physical, emotional, or sexual; exposure to domestic violence; severe natural disasters; war; abandonment; kidnapping; severe bullying; personal attack by another person or an animal; witness to violence in the neighborhood or school setting; or a medical procedure such as surgery, accident, or serious illness (Moroz, 2005).

Childhood trauma can be the result of a sudden, time-limited external event or a chronic and pervasive series of events. The mental consequence of this trauma may result in the child becoming temporarily helpless and facing numerous internal changes stimulated by the external events. When these internal changes are lasting they then become detrimental to the child (Perry *et al.*, 1995; Terr, 1990; Terr, 2003). With the highest incidence of child maltreatment occurring in children aged birth to five (Children's Bureau, 2011; Liberman *et al.*, 2011), there is a call for more involvement in early childhood mental health by those committed to the human service field. Children may experience trauma differently based on the frequency of their exposure, the

duration of time the traumatic events occur in their lifetime, and from who the trauma originated. Complex trauma differs from single-event trauma and potentially causes increased detrimental effects to children.

Complex trauma. Terr (2003), a child psychiatrist, defined two different types of children's psychological trauma exposure. Type I trauma refers to a single-event, short-term occurrence, which happens suddenly. The majority of the time, Type I trauma occurs impersonally; not by another person, instead a random event or an accident. However, Type I trauma may also be interpersonal, in which the trauma is caused by another person. In contrast, Type II trauma is a repetitive or complex trauma, which generally refers to ongoing exposure (Terr, 2003). Type II trauma is a pervasive trauma that requires exposure to multiple traumatic events (Cook *et al.*, 2005).

Complex trauma, like Type II trauma, also refers to ongoing and repeated exposure to trauma, which occurs over an extended amount of time (Courtois, 2004). Courtois (2004) emphasizes that in order for trauma to be classified as complex it has to be repetitive, prolonged, or cumulative. However, complex trauma is also characterized by the interpersonal nature of the trauma exposure. Children may experience complex trauma in the way of physical, sexual, and emotional abuse, and neglect within their interpersonal relationships. This involves direct harm, exploitation, or maltreatment, which includes abandonment by the primary caregiver (Courtois, 2004; Courtois & Ford, 2013). Another aspect of complex trauma is the occurrence of an early life onset (van der Kolk, 2005), and frequent nature of occurrence at developmentally vulnerable times in the victim's life, especially during early childhood or adolescence (Courtois, 2004; Courtois & Ford, 2013). Complex trauma is representative of numerous factors, which have the ability to gravely affect the children who are exposed to complex traumatic events.

Children who have suffered noncomplex trauma have been found to be dissimilar in the ways they experience, internalize, and process their traumatic event when compared to children who are exposed to long-lasting and repetitive sources of complex trauma. The longer the duration and the higher the frequency of occurrence of the traumatic event, the more severe the posttraumatic effects are (Wamser-Nanney & Vandenberg, 2013). Children who have been exposed to complex trauma also present a higher rate of behavioral difficulties when compared to children who were exposed to traumatic events of less severity (Wamser-Nanney & Vandenberg, 2013). Children exposed to complex trauma will present different symptoms and will require different treatment interventions than children who have been exposed to noncomplex traumatic events. Causal reasons explaining the difference in these children's symptom presentation are due to the caregiver's role in the child's trauma exposure. When a child's caregiver is involved in mistreatment, the child's universal expectation that they can rely on their caregiver is violated. Children no longer view their caregivers as "trustworthy, nurturing, or protective" (Courtois & Ford, 2013, p.3). This breach of trust and loyalty effects the child's healthy development and starts a negative trajectory. Children may begin to have negative beliefs about themselves and others as well as negative behaviors, as they are now faced with the main priority of surviving threats and trauma without the assistance or protection from their caregiver (Courtois & Ford, 2013).

In 2011, in the United States, the Children's Bureau reports 681,000 children were victims of child maltreatment. When looking at the type of maltreatment that these children experienced, almost 80% were neglected, 18% were physically abused and 9% were sexually abused. Some of these children, unfortunately, underwent more than one type of abuse. The data on the age of the child victims indicates that almost half of the 681,000 were five and younger,

and over a quarter of the total population was age three and younger (Children's Bureau, 2011). This report paints a painfully sad picture of the reality of child maltreatment in the United States. Courtois and Ford (2013) agree with these findings stating that children are the "most traumatized class of humans around the globe" (p.12). However, the view of the general public does not align with this thinking paradigm, in that children are viewed as protected in their families, societies, and cultures (Courtois & Ford, 2013).

Children are a vulnerable population and when exposed to complex trauma their developing 'self' is compromised. Children will inevitably struggle with attachment security, self-integrity, self-worth, and self-regulation (Courtois & Ford, 2013). When children are exposed to complex trauma there is not only a significant threat to their physical well-being, but also to their psychological survival. A vast majority of children will unavoidably have lifelong difficulties related to their relationships, self-regulation abilities, attention alterations, identity, and even cognitive distortions due to their exposure to complex trauma (Lawson & Quinn, 2013). Children exposed to complex trauma, in comparison to Type I trauma, have a higher association for risk of development of PTSD, and effects that stretch beyond the scope of PTSD (Courtois & Ford, 2013). Exposure to complex trauma events also influences the development of the child's brain. How the brain is structured and how it functions is gravely effected in the short- and long-term (Courtois & Ford, 2013). Children who are exposed to complex trauma will develop differently than children who have been exposed to noncomplex trauma, or who have no trauma exposure. Complex trauma exposure has the ability to impact children's neurological development in a significant way.

Neurological issues. A traumatic event is a human experience and the experience is likely to change the trajectory of the life of the child. The human brain allows one to feel the

trauma experience throughout all the systems of the body. After the event, the brain attempts to process and internally address the trauma. The human brain is in charge of all system functioning in one's body. The following systems function and interact with one another and are affected by trauma: emotional, cognitive, behavior, social, and psychological (Perry *et al*, 1995).

Due to the different levels of functioning of the brain at different developmental increments, a child is more malleable than an adult to its experiences. We as human beings depend on our experiences. We use them to learn and inform our future. Cozolino (2002) asserts that experiencing trauma at an early age can impact the neuroanatomical networking and biochemical levels in the brain. These important aspects of the brain, in turn, impact the child's experience and adaptation throughout their future development.

The human brain is an organ that is multifaceted, complicated, and intricate. There are different parts of the brain, which are responsible for a variety of complex body systems and functions. Each of the brain's systems are made up of networks of nerve cells called neurons. The brain is comprised of over 100 billion neurons (Perry *et al*, 1995). There are three main parts to the brain: the brainstem, the limbic brain, and the cortical brain. These different parts develop in a progressive way in which the least complex area, the brain stem, develops first and the most complex, the cortical areas, develop last (Perry *et al*, 1995 & van der Kolk, 2003).

When experienced by a child, trauma impacts how the brain is wired and changes how neural systems are organized. Trauma in adulthood is a learning experience with the possibility of changing that person, but because the brain of an adult is already developed, the neurological wiring will not be impacted. This means the experiences a child has during the early states of development have the ability to determine the functional capacity of the brain (Perry *et al*, 1995). As humans interact with their environments and communicate internally with their brain

and body, neurons are constantly changing due to the signals they receive from the interaction and communication. As the change process happens, the ability to store information occurs, which leads to the basis for memory (Perry *et al*, 1995). When a child is exposed to a traumatic event, they experience a high state of arousal. Consistent high level arousal states lead to impairment in integrating areas of learning and memory (Cozolino, 2002).

Traumatic experiences change the way in which children's brains are wired, which leads to all subsequent experiences being organized around the early trauma experiences. Thus, creating the "state of mind, brain, and body" (Cozolino, 2002) that was adapted after traumatic experiences occur early in life. At birth, infants are wired to allow stress to shape their brain in a way that mandates one to remember one's experiences, which are pertinent to survival. As one experiences things in the external world, the brain attempts to make sense of these things internally (Cozolino, 2002). Having experiences allows our brain to develop the guide through which all future experiences will be filtered. Therefore, when one is exposed to a traumatic experience in early childhood, the brain is developing and creating a map based on the trauma to which all future experiences will be compared. Then, there is a higher likelihood that the child will be sensitized to their traumatic event. This is particularly detrimental for a child who is exposed to repetitive trauma, as they will now use their trauma experiences as a base for exploration and deduction of meaning in the world.

A noted researcher in the area of trauma, van der Kolk (2003), reports that experiences of trauma change the anticipation and focus areas of children. He also asserts, the way in which children organize and process information is altered. These alterations in the child's ability to perceive threats are apparent in the way the child thinks, feels, behaves, as well as their ability to regulate themselves physically (van der Kolk, 2003). The presence of extreme stress in a child

activates their fight or flight response, which is connected to their nervous systems. When this response is activated the production of cortisol increases, allowing the child to remember their survival experiences and then recreate them. However, high levels of cortisol also affect brain development and can even cause the destruction of brain cells (Moroz, 2005). These changes in normal system development of the individual will have lasting effects on their development into adolescence and adulthood.

Characteristics of trauma. In studying children who have been exposed to trauma, themes of common characteristics found in these children began to emerge. Terr (2003) presents the four characteristics commonly found in most cases of childhood trauma; including: re-experiencing the event through memory, repetitive behaviors, trauma-specific fears, and changes in attitudes about people, life and the future. Each of the four characteristics are often present in childhood trauma victims and contribute to a higher rate of diagnoses in this population. These characteristics may last for years after the trauma events cease and are frequently found in adult populations that carry mental health diagnoses (Terr, 2003).

The occurrences of these four characteristics in children are different from trauma characteristics of adults. Adults tend to have repetitive dreams and more intrusive memories than children. Children seem to experience their memories at times of leisure, when they are relaxed. Trauma memories tend to be re-seen and the re-experience of the trauma is highly visual, even if the original trauma was not visual (Terr, 2003). Children have a tendency to repeat behaviors that they do not necessarily know are associated with their trauma experience. They may repetitively play out their trauma, or they may have a repetitive physical response that is based on their original thoughts during their response to their trauma.

The characteristics of trauma-specific fears and a change in attitude about people, life and the future have the ability to profoundly impact one's development. Van der Kolk and colleagues (1996) suggest that a long-term effect of trauma is that the individual has a conditioned fear response to trauma-related stimuli. Trauma-specific fears can be directly associated with the type of trauma that one endured. However, they can also take shape into general fears such as, the dark, being alone, or strangers (Terr, 2003). Van der Kolk *et al.* (1996) also supports Terr's (2003) idea that trauma victims characteristically change their attitudes about their life, the people in their life, and their future. Trauma victims may engage in social avoidance and begin to lose their meaningful attachment relationships; they may also tend to have a decrease in trust, hope, and a sense of personal agency. Lastly, trauma victims lack interest in preparation for their futures. According to Terr (2003), children lose interest in preparing for the future as the future represents a place for continued trauma. These characteristics are the cornerstones of the way trauma represents itself in the lives of children; however, there are numerous ways in which traumatized children may be affected developmentally.

Effects on development. Children who are exposed to trauma in early childhood are faced with developmental difficulties that span all areas of development. They struggle in broad areas of functioning such as physical, psychological, cognitive, social, emotional, and moral, as well as specific areas with-in each of these categories. Cook and her colleagues (2005) assert that children who are exposed to maltreatment and trauma experience multidimensional and complex consequences that are both immediate and long-term (Cook *et al.*, 2005). Van der Kolk (2005) also supports this as he reports that children who experience trauma in childhood are faced with deficits in numerous areas of functioning. In comparison to non-abused children, children who

experience early trauma have extensive negative effects and higher levels of behavioral and emotional problems (Moroz, 2005).

There are numerous factors that dictate whether or not symptoms will be present after a child is exposed to trauma, and also which symptoms will appear within the child. Van der Kolk (2003) states that these factors include: the age the child is when they experience their first traumatic experience, the frequency of the trauma, and the role that the child's caregiver has in regard to their trauma. Cozolino (2002) also communicates the degree of impact the trauma has on the child is dependent on the stage of development the child is in during onset, the duration and degree of the trauma as well as the presence of past traumatization.

There are several areas of development that are impacted when a child is exposed to a traumatic experience. Cook and colleagues (2005) explain the seven domains of impairment impacting a child exposed to complex trauma. These domains are centered on issues of "self-regulation, aggression against self and others, problems with attention and dissociation, physical problems, and difficulties in self-concept and capacity to negotiate satisfactory interpersonal relationships." (van der Kolk, 2003)

An important domain that is gravely impacted by trauma is attachment. In one of his articles in which he discusses trauma, van der Kolk (2003) asserted that the trauma must be viewed in the context of the attachment relationship. Children who have impairments in this area struggle with: boundaries, distrust, social isolation, attunement, and interpersonal relationships. These areas of development are all dependent on the quality of the attachment relationship that the child has to the primary caregiver. The child either develops typically in these areas or is impaired due to their relationship with the caregiver. Cook and colleagues (2005) support the

claim that complex trauma exposure negatively influences interpersonal relatedness. Cozolino (2002) states that social withdrawal is a common obstacle for traumatized children.

A child's biology is impacted by trauma; issues around coordination, balance, sensorimotor developments, somatization and a wide range of medical problems are categorized as present biological impairments. Children who are trauma victims run the risk of not being able to regulate stress emotions due to the underdevelopment in their brain capacity (Cook *et al.*, 2005). Moroz (2005) also labels physical health problems and somatization as well-known characteristics prevalent in children who have experienced trauma.

Cognition is a domain that has proven to be impacted by a child's exposure to trauma by numerous researchers. When compared with non-abused children, children who have trauma exposure have impaired cognitive functioning; deficits are found in overall IQ as well as language development. Cook and colleagues (2005) report that children who suffer from maltreatment are referred at a much higher rate for special education services. Moroz (2005) declares that children exposed to complex trauma are delayed in school readiness and suffer in school performance due to their lower cognitive functioning. Lieberman and colleagues (2011) report that abused children have a significant deficit in their motivation to learn. This coupled with their cognitive inabilities results in issues with delays in language development and low school performance.

The domain of behavioral control impacts children with trauma histories and represents itself by children having under or over controlled behaviors. Some examples of behaviors that would be categorized into this domain might include the following: poor impulse control, self-destructive behavior, aggression, sleep or eating disturbances, over compliance or oppositional behavior, and reenactment of trauma in their play or behavior (Cook *et al.*, 2005). Numerous

research articles present information on the difficulties children who have experienced trauma have regarding controlling their behaviors. Moroz (2005) reports that children may have behavior difficulties and gives examples of aggression, conduct disorder, eating disorders, and sexualized behavior. When sexualized behavior is present, this is most likely a reenactment of experienced trauma. Sleep disturbances and an exaggerated startle response are reported in Terr's (2003) article on trauma as behavior characteristics that are present. Lieberman and colleagues (2011) focus on the behavior of the re-experiencing the trauma thought reenactment in play, nightmares, and being distressed when faced with a reminder of their trauma. According to Cozolino (2002), the child's ability to have adaptable behavior is significantly lower.

Affect regulation is another domain. This process is the acknowledgement and correct identification of one's internal emotional experiences. Knowing and being able to describe what is going on internally with one's emotions also involves giving name to and expressing feelings states (Cook *et al.*, 2005). In his article Cozolino, (2002) asserts that due to the biochemical and neuron changes in the brain, children who experience trauma have difficulties with emotional regulation. Dissociation is another domain, and it is connected to affect regulation due to the detachment from emotions and self. Children who are maltreated adapt using dissociation by automatizing behavior, compartmentalizing memories and feelings, and detaching from the awareness of self and emotions (Cook *et al.*, 2005).

Lastly, the domain of one's self concept is greatly impacted by early trauma. As a child develops, they typically are able to acquire an integrated sense of self and identity through their relationship with their caregiver. However, when children are frequently exposed to harm and rejection they are unable to develop their age-appropriate competencies. These children have a tendency to develop a sense of self that is helpless, defective, and unlovable (Cook *et al.*, 2005).

Moroz (2005) asserts that the most devastating effect is the interference of the child's ability to develop individualization and differentiate their separate sense of self. She reports that this is due to their fixation with their survival, as it becomes the focus of their interactions and activities in response to their environment. Abused children are forced to place survival as their number one priority. Consequently, they are unable to relax, trust people in their environment, or explore their feelings, ideas, and interests, which leads to the child losing their themselves and their sense of self.

There are some other symptoms that have been identified in the research to be characteristic of children who have suffered trauma that cover multiple domains and affect the majority of children. Moroz (2005) found a wide range of symptoms varying in severity. Some mental health concerns are: mood swings, emotional irritability, anger and aggression, anxiety and depression, and dissociative episodes. Terr (2003) in her in-depth research on trauma has also labeled hypervigilance, fears of the mundane, deliberate avoidance, panic, and developmental regressions as characteristics of trauma survivors that are well known to effect development. Lieberman and colleagues (2011) report after a child experiences chronic trauma they come to think that trauma expectations are the norm and develop responses to trauma, which are exhibited as symptoms such as constriction of play, exploration and learning, hypervigilance, and re-experiencing the trauma in a variety of ways that may lead to the development of new symptoms.

Exposure to a traumatic event has a long lasting effect on the child. The effects on development in childhood due to the trauma can have lasting impressions long into adulthood (Cook *et al.*, 2005; Moroz, 2005; Terr, 2003). Cook and colleagues (2005) suggest that once in adulthood, individuals may suffer from difficulties in a wide range of areas. Development of

psychiatric and addictive/substance abuse issues and chronic medical illnesses are prevalent. Legal and vocational issues are likely, as well as intimate family problems as a result of trauma exposure in childhood. Terr (2003) also reports these same characteristics present in the adults that she has studied, with the addition of violent behavior in some and extremes of passivity in others.

Individuals who are victimized in early childhood by trauma are at an increased risk as they progress throughout their lives to be re-victimized and have additional trauma exposure. Perry has suggested that a chain of events is set in motion when a child experiences severe trauma in early childhood that creates a negative trajectory (Perry *et al*, 1995). Cook and colleagues agree with the idea that trauma exposure in childhood increases the likelihood and risk that there will be repeated trauma throughout the life cycle, which will lead to cumulative impairments within the individual. Moroz (2005) adds that traumatized children tend to develop a sense of self in which they believe that something is inherently wrong with them and that their trauma exposure is somehow their fault. These feelings of hate, helplessness, being unloved, and being unworthy lead to the children having poor self-image, which creates a “victim state of body-mind-spirit” (Moroz, 2005, p. 5). This view of self creates the risk of re-victimization and subsequent trauma exposure. The reality of the aforementioned affects on the development of children who experience trauma in early childhood forces us to realize that the impairments have a wide reach across multiple areas of functioning. These impairments in children’s development include psychiatric symptoms that can be evaluated and diagnosed.

Posttraumatic Stress Disorder (PTSD)

Children who experience trauma may meet criteria for many different types of disorders. Children who are vulnerable and who experience severe and prolonged trauma are more likely to

develop a trauma related disorder (van der Kolk, 2005). One of the more prevalent disorders that often appear in children who have a trauma history is Posttraumatic Stress Disorder. While there is a wide array of possible diagnoses for children suffering from trauma exposure, this paper will place focus on PTSD. However, one must view PTSD in context of the trauma victim, which means that there are co-morbid mental health symptoms/disorders that are present as well.

Criterion for diagnosis. The Department of Veteran's Affairs, who conduct extensive PTSD research, offer clarity on events that may cause PTSD in children. They propose that physical or sexual abuse; violent crimes, domestic or community violence, war, and others could be the catalyst for symptomology (Hamblen & Barnett, 2012). Posttraumatic stress disorder develops as the result of a person being exposed to an event in which they experience unwanted trauma. The inability for an individual to appropriately respond to stress due to the regulation difficulties in neurological processing is an accurate indication that PTSD will develop. The symptoms one exhibits due to PTSD reflect the loss of integration in vital neural networks that operate areas of cognition, affect, and behavior (Cozolino, 2002).

Posttraumatic stress disorder is determined by a set of criteria outlined by the American Psychiatric Association's *Diagnostic and Statistical Manual (DSM-IV-TR)* (American Psychiatric Association, 2000). The person who is being evaluated for PTSD must have "experienced, witnessed, or confronted with an event(s) that involve actual or threatened death or serious injury, or a threat to the physical integrity of self or others" in order to be considered for this diagnosis (American Psychiatric Association, 2000). The individual must also have current symptoms that meet criteria in cluster areas of: persistently re-experiencing the event, avoidance, numbing, and arousal. Individuals are required to have a certain number of symptoms in each category and the duration of the symptoms must extend for longer than one months time. These

symptoms must also cause significant distress in areas of the individuals functioning, such as social or occupational (American Psychiatric Association, 2000).

Diagnostic concerns. There has been much scrutiny around the issue of diagnosing PTSD in children. Researchers report that the diagnostic criteria is not encompassing of children's developmental issues or their ability to verbalize their symptoms and concerns (van der Kolk, 2005). Professionals are encouraged to gain an understanding of PTSD, its diagnostic criteria, and the associated symptomology; otherwise this disorder has the potential to be overlooked. Overlooking the children's posttraumatic symptoms will affect numerous children, leaving them misdiagnosed, mistreated, or they could be left untreated (Morrisette, 1999).

A concrete and accurate number of children currently suffering with PTSD is hard to report. Research shows that the current diagnostic criterion is insufficient for the child population (Lieberman *et al.*, 2011; van der Kolk, 2005). This is due to the complexity of presenting symptoms in children who experience trauma during critical times during development. According to the National Center for PTSD (Hamblen & Barnett, 2012) there are no current studies reporting on the rates of PTSD in young children. However, they report on the rate of adolescents, aged 13-18, who have met criteria for PTSD in their lifetime to only be 5%. This data comes from a National Comorbidity Survey focusing on adolescents and includes 1,000 participants. The low percentage reported may be related to the inability of the current diagnostic materials to accurately assess for symptomology in this age group (Hamblen & Barnett, 2012).

In contrast, a supplement printed by the Journal of the American Academy of Child and Adolescent Psychiatry (AACAP) (1998) provides a review of studies regarding the PTSD rates in children and adolescents. It is indicated there are few studies that have been conducted to examine the rates of exposure to traumatic events and prevalence rates of PTSD in children and

adolescents and the development of PTSD criteria has made determining the prevalence quite difficult. There is an emphasis on studying children and adolescents that have been exposed to traumatic events as it is reported that 15% to 43% of girls and 14% to 43% of boys have been exposed to at least one traumatic event in their lifetime (AACAP, 1998). Rates of PTSD diagnosis for those children and adolescents that have been exposed to traumatic events range from 3% to 15% for girls and 1% to 6% for boys. Also, the prevalence for meeting criterion for PTSD is much higher in children and adolescent samples that are considered high risk. For example, it has been reported that children who have been sexually abused have a PTSD diagnostic rate of 90%, 77% of children who have witnessed a school shooting meet criteria, and 35% of urban youth who are exposed to community violence develop PTSD (AACAP, 1998). AACAP (1998) also suggest that even though there are several instruments available for the assessment of PTSD symptoms that none of the instruments are ideal alone and a multisource assessment is the preferred way in order to get an accurate representation of functioning.

The stages of development that children progress through in the first years of life, coupled with their inability to give a verbal self report make using traditional assessment criteria that was designed for an adult population difficult to use. Other factors that complicate the diagnosis are the reliance on parental report for an accurate description of their child's mental health as well as the timely task of observing the child in numerous environments to make a grounded opinion about the array of their deficits in multiple developmental domains. Some researchers are of the opinion that PTSD is not a sufficient enough diagnosis to encompass all of the difficulties that children face in all areas of development (Cook *et al.*, 2005). Due to the fact that PTSD is unable to incorporate the severity of trauma exposures during critical developmental periods, the majority of children do not meet the diagnostic criteria for PTSD.

Children often present with symptoms from a variety of disorders due to their maltreatment. Frequently, each of the disorders in consideration for diagnosis only encapsulates a portion of the trauma victim's limitations (van der Kolk, 2005); which often leads professionals to select the diagnosis that fits best when required to diagnosis, which is of no benefit to the child to have an incorrect or ill-informed diagnosis.

However, there is still support for PTSD as a diagnosis for children who have experienced trauma. The challenge is to be able to recognize the PTSD symptoms that are co-occurring with symptoms from other disorders. Van der Kolk and colleagues (2003) assert that it is difficult to be privy to a child's PTSD symptoms as they can be masked by more pressing symptoms from cognitive, affective, social, and physical areas. In their research on traumatized children, Perry and colleagues (1995) assert that childhood PTSD is prevalent across differing populations of traumatized and maltreated children. Nevertheless, it is increasingly more common for these children to present with an array of symptoms related to PTSD, behavioral disorders, anxieties, phobias, and depressive disorders. The introduction of co-morbid disorders becomes vital as children exposed to trauma are presenting with symptoms from a variety of disorders. An important aspect of co-morbid disorders is that they do not occur separately from the PTSD symptoms; all symptoms are happening co-currently and must be viewed as inseparable during assessment, diagnosis, and treatment (van der Kolk, 2005).

Potential co-morbid diagnoses. Preschool children represent a population that depends on others for an acceptable standard of care. A study conducted on almost 4,000 preschool children who were screened and evaluated for the prevalence of psychiatric disorders, reported that over 20% of the children qualified for a probable Axis I diagnosis (Lavigne *et al.*, 1996). Preschool children are potentially at risk for the development of a psychiatric disorder.

Furthermore, preschool children who experience trauma have a higher probability of having a mental health diagnosis.

PTSD may not be the most common diagnosis for children who have experience early trauma, but it is still very prevalent (Cook *et al*, 2005; van der Kolk, 2005). Terr (2003) asserts that when looking at the clinical manifestations of traumatized children one could see a wide gamut of disorders present themselves. Some of these disorders include “conduct disorder, borderline personality, major affective disorder, attention deficit hyperactivity, phobic disorder, dissociate disorder, obsessive-compulsive disorder, panic, disorder, and adjustment disorder” (p.322). Lieberman and colleagues (2011) support Terr’s (2003) findings and include separation anxiety disorder, which van der Kolk, (2005) states is the most common diagnosis of children who have experienced trauma. Cozolino (2002) and Terr (2003) also add the presence of depressive disorders and dissociative disorders.

Research done on a group of adolescents with PTSD and comorbid disorders suggests that comorbid PTSD occurred much more frequently than non-comorbid PTSD. Results also suggest that negative outcomes increase based on the higher rate of exposure to traumatic events (Macdonald, Danielson, Resnick, Saunders, & Kilpatrick, 2010). Other research done on children and adolescents exposed to traumatic events suggest that having a history of traumatic events followed by repeat exposure predicts the development of trauma-related symptoms and an increase in development of anxiety, depressive, or behavioral disorders (Copeland, Keeler, Angold, & Costello, 2007). Silverman, Reinherz, and Giaconia (1996) concur with the previous presented research in that they conducted a longitudinal study on a group followed from Kindergarten though the age of 21. Eleven percent of the sample reported physical or sexual abuse and 17% of that group reported both physical and sexual abuse. Among those that reported

an abuse history, 80% met criteria for at least one psychiatric disorder in comparison to their non-abused peers.

Famularo, Fenton, Kinsherff, and Augustyn (1996) conducted a study on maltreated and traumatized children to find the prevalence of co-morbid mental health disorders. The study compares children who were maltreated and developed PTSD to those who were maltreated and did not meet PTSD criteria in order to determine the unique characteristics of PTSD. Children involved in the study had been removed from the care of their parents due to traumatization and maltreatment and were currently involved in the juvenile/family court system. Researchers gave special attention to issues of true co-morbidity versus inaccurate diagnosis due to symptom overlap by applying strict criteria. Results indicated that the presence of PTSD suggests a “substantial likelihood of other formal diagnosis” (p.958). The study suggests that children who are diagnosed with PTSD demonstrate concurrent “ADHD, anxiety disorders (panic, phobic, overanxious, simply phobia) and a tendency toward mood disorders (major depressive, dysthymic)” (p.959). Findings also suggest that there was a significant presence of brief psychotic disorder or psychotic disorder NOS as the symptoms present for these disorders are not typically associated with PTSD (Famularo *et al.*, 1996). Researchers assert that these findings significantly correlate PTSD with an increase in comorbid mental health diagnoses.

The results of the above mentioned research on potential co-morbid diagnoses in children with PTSD offer unwavering support that children with PTSD are at increased risk for the development of a mental health disorder. Researchers stress the importance of utilizing proper assessment and diagnostic materials in order to distinguish between the symptoms that the child presents. Correct diagnosis and treatment interventions are crucial to the management and resolution of symptoms.

Development of alternative diagnostic criteria. Diagnosing trauma related disorders is something that has gained traction only recently. PTSD was not available in the DSM for diagnosis, for adult or children, until 1980. Recently, an analysis was done on the diagnostic criteria for PTSD; the findings show an inadequacy for application to young children. Today there are ten times as many maltreated children as there are combat soldiers with PTSD, but the children fall into a diagnostic void (Hamblen & Barnett, 2012). This strongly calls for alternate diagnostic tools to be developed.

A variety of researchers have developed tools that assess young children for PTSD with criteria that are more suitable for their developmental levels and clusters of symptoms. Scheeringa and colleagues (1995) conducted numerous research studies regarding traumatized children and their ability to be diagnosed with PTSD using standard DSM diagnostic criteria. When they realized that even though children presented with characteristic posttraumatic symptoms, they were unable to be diagnosed due to the nature of the assessment requirements. They remedied this gap in diagnostic criteria by developing Alternative Criteria for posttraumatic stress disorder in children. This assessment tool and others like it served as the basis for the formation of a *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-3)*. This served as the first system for diagnosing infants and toddlers that was grounded in development (Zero to Three, 2012). Since its first publication in the mid-1990's, a revision has been printed, in 2005, that aims to include more updated and clinically relevant diagnostic and assessment criteria that has been informed by empirical research.

Another way in which assessment and diagnostic tools are being changed is with the DSM-V publication. A number of changes are being applied to the diagnosis of PTSD. The

diagnosis is now part of a new chapter focusing on trauma and stress related disorders. There are alterations to the clusters of symptoms and a heavier focus on the present behavioral symptoms. However, the biggest change is the addition of specific preschool subtype, which focuses on children under the age of six (American Psychiatric Association, 2013). These changes allow professionals to provide a more accurate assessment and diagnosis to children in all developmental and mental health areas, as well as PTSD specifically.

Play Therapy

As children grow they progress through multiple stages of development. In the early states of their development, children's brains are still developing and they are unable to communicate in the way that adults communicate (Gil, 1991). Children do not have the cognitive capacities, or the verbal skills to engage in traditional talk therapy. Professionals working with children must learn to communicate with them using their preferred means of communication, which is play (Landreth, 2002).

Play is the preferred vehicle for communication for children. This style of communication differs from that of adults who tend to use verbal expression. However, children do not often have the verbal capacity or cognitive integration to convey their feelings or process their life events. Play offers an alternative way to communicate; play is not something that children need to be made to do nor is play something that needs to be taught. Rather, play is innate, spontaneous, voluntary, and an enjoyable way for children to communicate (Landreth, 2002).

Developmental perspective. Children's worlds are made up of concrete realities and their experiences depend on their current stage of development. Landreth (2002) discusses how crucial it is to understand children from their developmental perspective. He also emphasizes that

children be approached and understood from their developmental experience and not be seen as miniature adults. Norton & Norton, (1997) add that until a certain level of development, children do not understand the world at a cognitive level as they process at an experiential level. Landreth (2002) addresses the point that children who are developing often times are incapable of appropriately accessing and expressing their feelings verbally due to a lack in their verbal and cognitive facilities. They are unable to understand the intensity of their feelings and do not have the complex vocabulary to express what they are actually feeling.

Children need to communicate their emotions in a more primitive way, as they lack the skills to appropriately express them verbally. As a result, children communicate through their play (Davenport & Bourgeois, 2008; Landreth, 2002; Gil, 1991; Norton & Norton, 1997; Schaeffer, 1994). Landreth (2002) compares the method of adult communication to that of the communication of children; the method of communication and the manner of expression are different; however, the expressions and feelings are the same as adults. When looking at this point from a play perspective Landreth (2002) asserts, “toys are used like words by children, and play is their language” (p.16). Using their language of play, children are able to give a voice to their inner worlds; they are able to share their lived experience. Children are able to express their feelings about themselves and others as well as their personal experiences in a meaningful way (Norton & Norton, 1997).

Majority of children are comfortable with play; they do not need to be taught how to play, due to it being spontaneous, self-initiated and enjoyable. Landreth (2002) presents the idea that when children play they are using their self-expression to reveal “what the child has experienced; reactions to what was experienced; feelings about that was experienced; what the child wishes, wants, or needs; and the child’s perception of self” (p.18). When children play and

“play out” their inner worlds or feelings, thoughts, and experiences they are engaging in “dynamic and self-healing process” (p.14). Because they depend on their caregivers, children do not experience many situations in which they have control. During play, they are able to control their lives and are in control of the play and the direction that it takes. Children thrive on the sense of feeling in control, and having a sense of mastery, not actually being in control (Landreth, 2002). Children can change the outcome of experiences that were unmanageable in actuality to situations in which they have mastery over in their play. When children feel they have some control and mastery they can have healthy emotional development and mental health (Landreth, 2002).

School-aged children have difficulties that are expressed either as internalizing or externalizing symptoms. Internalizing symptoms can include: anxiety, depression, and withdrawal. While externalizing symptoms are: impulsivity, aggression, and acting out. Benedict and Schofield (2010) assert that preschool children’s issues are very different; however, as they do not differentiate between the two and have symptoms in both internal and external areas simultaneously. The developmental areas that these preschool and school-aged children represent mark a big difference in cognitive and affect processing abilities. An intervention that can attend to both of these areas is needed in order to best serve preschool children with problem behaviors. Benedict and Schofield (2010) report that play therapy is an ideal intervention for the preschool age group who has experienced complex traumatic events. A therapist that is open, accepting, unstructured, and kind during the therapy, supports the wide range of symptoms exhibited by preschool children. Play therapy also offers an ideal setting in which children are able to express themselves and their feelings, with their limited ability, as it is not driven by verbal communication.

Definition and history. The United States Association for Play Therapy (APT) defines play therapy as "the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development" (Association for Play Therapy, 2013). Landreth adds to the definition by stating that play therapy includes "a dynamic interpersonal relationship between a child and a therapist" in which the therapist "facilitates the development of a safe relationship for the child to fully express and explore self" (Landreth, 2002, p.16). Davenport and Bourgeois (2008) inform us through theory and empirical research that we learn that play is an essential childhood activity, which the field of play therapy has built its foundation.

One of the first pioneers of clinically treating children was Sigmund Freud. His clinical work was focused on adults; however, he was inspired by his adult patients to delve into the experiences and emotional development of children (Bromfield, 2003). He laid the foundation for a psychodynamic focus on play therapy. One of the first people to formally treat children with talk and play therapy was a teacher from Vienna in the 1920's, Hermine von Hug-Hellmuth. She discussed how the treatment of children and adults was similar in that the end goal is to restore the individual's psyche to a healthy state (Bromfield, 2003). Hug-Hellmuth was the first therapist to stress the importance of play when treating a child and when doing therapy with children, she provided them with a variety of materials so they could express themselves appropriately (Landreth, 2002). One of the other crucial concepts that Hug-Hellmuth appreciated was the familial influence on the children; she asserted that in her experience, much of the difficulties that children were facing were found to stem from their parent's unresolved problems (Bromfield, 2003).

A few other pioneers of the field of play therapy are Melanie Klein and Anna Freud. Melanie Klein and Anna Freud are two of the most cited in the beginnings of play therapy. They both placed great value in the experience and development of childhood and the use of play for understanding and healing (Bromfield, 2003). However, Klein compared children to adults and focused her work on making interpretations in relation to the child's unconscious. Anna Freud, on the other hand, employed methods that encouraged conscious understanding on the child's part of their experiences, thoughts, feelings, and behaviors. She understood that their external behaviors were a result of their internal worlds and their preferred method of coping with their life's struggles, traumas, and anxieties. Anna Freud also realized that children are part of bigger systems and encouraged parent and school involvement in the child's therapy (Bromfield, 2003). She is also credited with being one of the first therapists to encourage the client to align with her. The establishment of an emotional relationship between the child and the therapist is vital to have in place before the therapist can come to conclusions about the motivation of children's play (Landreth, 2002).

Carl Gustav Jung is another notable name in the development of play therapy. Jung and Sigmund Freud had a close personal and professional relationship although they represented different fields. Jung was a psychiatrist who was known for his research and contribution to the field of psychology and the development of the psyche in the early 20th century (Perry, 2003). Due to their emerging differences Freud and Jung stopped collaborating professionally and ended their personal relationship. Jung reports feeling lost after the dissolution of his relationship with Freud and consequently began playing, as he once did as a child (Perry, 2003). He soon realized through his play he was able to express his emotions and fantasies that, without play, would have otherwise overwhelmed him. Jung noted that the result of his play was an expression

of his emotional turmoil. Once he realized this, Jung was able to process and reintegrate, not only his feelings but also the causal issues in a less overwhelming way (Perry, 2003, p.18). Through this experience, Jung was able to create and develop the theory of play therapy; which numerous theorists and members of the field have adapted and furthered over time.

Types of Play Therapy. One of the most common types of play therapy used currently is child-centered play therapy. Carl Rogers is credited for the creation of this model of play therapy in the 1950's; his student, Virginia Axline further adapted the model into what it looks like currently (Sweeny & Landreth, 2003). This model focuses on the children and who they are as a person and not on the problems, symptoms, or diagnosis. The therapist acts as a facilitator and "fellow explorer on a journey with a child on a mission of self-discovery" (Sweeny & Landreth, 2003, p.76). Rodgers emphasized the developmental process of children was a crucial part of them. Due to the fact that each child holds the belief they are the center of a world of continually new and changing experiences (Sweeny & Landreth, 2003).

Another form of play therapy that is popular and unique is filial play therapy. This model separates itself from other models with the distinct element of including the child's parent as the primary provider of the therapy (Guerney, 2003). The therapist guides and supports the parent in their role as therapist and remains part of the therapeutic process with the child. This model was built on the child-centered model and included parents as a way to ensure better outcomes for the child clients (Guerney, 2003).

Play therapy can also be directive or nondirective. Play therapists and their child clients each take on roles in the therapeutic process. The therapist has the ability to take on a directive role or a nondirective role and may do so for a variety of reasons. Directive play therapy allows the therapist to lead the child in play. On the other hand, nondirective play therapy allows the

child to be in control of their play (Landreth, 2002). When using this model, therapists do not change or control the child or their play. The theory is that each and every decision the child makes during play is due to their drive for self-realization (Landreth, 2002). The goal of the therapist is to support the child in self-awareness and self-direction. Nondirective play therapy is similar in nature to child-centered play therapy.

Play Therapy, Trauma, and PTSD. It is necessary for children to undergo certain experiences at each developmental level in order to progress to higher cognitive development levels, which assist with competence and understanding. By having these experiences, it prepares children to attain and advance to the next stage of development (Norton & Norton, 1997). Norton and Norton (1997) assert that when a child is exposed to mental, physical, or emotional abuse or a trauma such as death or divorce, their ability to understand and be influenced by experiences in their current developmental level is affected. They are unable to reap the benefits of their current developmental stage because, due to their abuse or trauma history, they are exerting their emotional energy into their self-protection. If they cannot take in the experiences at their current developmental level, they are not going to appropriately progress to higher developmental levels. Children become fixated in the developmental stage in which their abuse and/or trauma occurred (Norton & Norton, 1997). These authors state: due to the fact that children communicate through play, in order to resolve their pain they must experience their pain through their play.

Children who have experienced a trauma often engage in posttraumatic play naturally. Schaefer (1994) reports that it was Freud who pioneered the idea that children recreate their trauma in play and that the frequency of the reenactments were linked to the intensity of the trauma. Gil (1991) reports on posttraumatic play, in that the reason traumatized children engage in reenactment of the event is in order to attempt to master their trauma. The goal of the

reenactment is to achieve a sense of mastery over the event (Gil, 1991; van der Kolk, 2003). The act of reenacting their trauma event is often times an unconscious compulsion and the child may not understand the reason they are engaging in the reenactment or recognize they are playing out their trauma (Gil, 1991). However, by reenacting their trauma in the context of play therapy, children are provided with corrective and reparative experiences in a safe and controlled environment. Each time the trauma is reenacted through play, the negative effect of the child that is associated with the trauma lessens and the sense of mastery over the event increases (Schaefer, 1994). This approach also allows for children, with adult support, to eventually be aware of what has happened to them on a conscious level; then understand it and hopefully, learn to tolerate it. This way children will be able to realize what is happening to them in present time and respond to their current environment instead of recreating their past trauma which is conveyed through their biology, emotions, and behaviors (Gil, 1991; van der Kolk, 2003).

Terr (1990) informs there are two different types of reenactments in which children can engage; behavioral manifestations and play dramatizations. Children's reaction and coping of their trauma will be expressed in ways that are different to each individual. Freud contributes that children engage in unconscious reenactments in their play. He makes it clear that these reenactments are associated with the original traumatic event to which they were exposed (Schaefer, 1994). The reenactments also depend on the intensity and duration of the original trauma. Freud asserts that when children engage in play reenactments, they are strengthening their sense of mastery over the traumatic event and weakening the negative affect that is associated with the trauma (Schaefer, 1994).

Play is the way children communicate. Through their play, children are able to therapeutically "uncover concerns and release pent-up feelings" (Gil, 1991, p. 72). The purpose

and goal of play therapy is for the children to resolve their trauma experience through their play reenactments. Resolution can be accomplished by the play therapist fostering reparative experiences surrounding the trauma (Gil, 1991). The reparative approach, which promotes resolution, is implemented in order for the children to have a way to process their trauma so that it is given meaning, understood and stored as a tolerated memory (Gil, 1991). Van der Kolk (2003) asserts that when treating children who have been exposed to trauma, it is crucial to establish an environment of safety for the children and to provide boundaries. Gil (1991) concurs with the importance of the child having a sense of safety, trust, and wellbeing in their interactions with the therapist. This provides a corrective approach for children in their participation in a relationship. Play therapy proves to be an effective intervention for the treatment and resolution of trauma symptoms in children (Landreth, 2002; Ray, Bratton, Rhine, & Jones, 2001; Schaefer 1994).

A clear link has been established between trauma and the development of PTSD (Cozolino, 2002; Hamblen & Barnett, 2012; van der Kolk, 2005). Van der Kolk asserts that when children are exposed to severe and persistent trauma, they are at an increased risk for the development of a trauma-related disorder, the most frequent being PTSD. Given the aforementioned efficacy of play therapy in the treatment of trauma there is a connection to play therapy also being effective in treating PTSD symptoms, considering that PTSD is a trauma-related disorder.

Play therapy and mental health/co-morbid disorders. Play therapy is an intervention implemented by mental health professionals in a variety of different settings and for the treatment of a plethora of mental health disorders in children. The following research highlights

a few of the mental health disorders that are frequently found to be co-morbid with PTSD and how effective play therapy is that disorder.

Research conducted on young children in the homeless population implemented child-centered group therapy in hopes of reducing anxiety and depression symptoms (Baggerly, 2004). Results show a reduction in physiological anxiety symptoms and overall anxiety. Findings also suggest that group child-centered play therapy was effective in the reduction of depressive symptoms (Baggerly, 2004).

Milos and Reiss (1982) used separation-relevant play with children aged two to six who had separation anxiety, as identified by their teachers, in order to reduce their anxiety. Children were assigned to one of three thematic play conditions (free play, directed play, and modeling), a fourth group served as the control group. Children in the three thematic playgroups received results of lower posttest anxiety, when compared with the control group. Findings also indicate a correlation between the higher the quality of play than the lower the anxiety scores (Milos & Reiss, 1982).

Attention deficit hyperactivity disorder is a disorder that has continuously correlated with PTSD. Ray, Schottelkorb, and Tsai (2007) used child-centered play therapy with elementary school aged children with ADHD. Children who participated in the play therapy demonstrated statistically significant improvements in their ADHD symptoms as well as a decrease in their anxiety/withdrawal symptoms.

Conceptual Framework

Attachment Theory

Attachment theory is an important theoretical framework and has a strong relationship to trauma and how trauma is processed. John Bowlby is credited as a pioneer of attachment theory and conducted extensive research into the development of the theory. Bowlby published numerous papers and books on attachment theory. Attachment theory speaks to the relationship an infant has with his/her caregiver. Attachment can be seen as a behavioral system, that is inborn, in which the brain evolves with respect to the caregiver (Bowlby, 1982). The attachment system is what determines the infant's survival as it drives the infant to seek proximity to caregivers and to establish communication with them.

Mary Ainsworth, another pioneer of attachment theory, is known for her work observing infants and their mothers and analyzing their interactions (Bowlby, 1982). Ainsworth is also credited with the development of the strange situation, which is a laboratory-based study that looked at infants' responses to brief separations from, and reunions with a caregiver. Results showed there were classifications of infant-caregiver attachment (Main, 2000). If an attachment was organized it was classified as secure, insecure-avoidant, or insecure-ambivalent. Ainsworth recognized the infant's ability to have a secure attachment was directly related to the mother's sensitivity to the infant's signals and attempts to communicate with the mother. On the other hand, insecure attachments resulted from the mother responding to the infant's signals and communication with unpredictability or rejection (Main, 2000).

Mary Main is the final pioneer of attachment theory; she contributed by labeling infants who had participated in Ainsworth's strange situation who did not fit into an organized category, as disorganized (Hesse & Main, 2000). Disorganized attachment is characterized by interruptions

and abnormalities in the infant's organization of attachment. Originally, children who had been maltreated were difficult to place in one of the organized categories, which was one of the catalysts for the development of the disorganized category (Hesse & Main, 2000). Main also developed the Adult Attachment Interview (AAI), which is a semi-structured set of questions designed to determine an adult's state of mind in regard to attachment. Adults are also given categories with regard to their state of mind in regard to attachment, there are three organized types: secure/autonomous, dismissing, and preoccupied (Main, 2000). A disorganized category also was found and labeled as unresolved/disoriented (Hesse & Main, 2000).

Internal working model. During early development, attachment is defined as children needed to maintain proximity to caregivers, the child's ability to use their caregiver as secure base for exploration of unfamiliar environments, and the use of the caregiver as a symbol of safety when alarmed (Main, 2000). Attachment relationships create the foundation from which a child's mind develops. As the child grows they internalize their attachment relationships thus creating an internal working model of self, which is referred to as a mental mode (Siegel, 1999).

Trauma perspective. Van der Kolk (2003) states, "It is virtually impossible to discuss trauma in children without addressing the quality of parental attachment bond" (p.294). Due to the fact that an infant's brain development is dependent on interpersonal experiences, the attachment relationship is viewed as a crucial aspect of development. Infants learn from their caregivers and their brain develops due to the level of interaction or neglect from said caregiver. Hence, trauma experiences have great potential to damage the relationship between caregivers and their children. The understanding that the caregiver is a representation of safety and protection is challenged along with their trust in the caregiver (Lieberman et al., 2011). However, the type of attachment that the child has to their caregiver determines their ability to resolve a

traumatic experience. Children who have a secure attachment are better able to regulate their stress response than children with an insecure attachment. Further, any organized attachment style can regulate better than the disorganized attachment style (Hesse & Main, 2000; Main, 2000). The ability for a child to understand and process a traumatic event has a direct correlation to that child's attachment style to his/her caregiver.

When trauma is experienced during early development the effects are extensive and damaging to the child. These effects can be further compromised when the child experiences trauma or abuse from their caregiver to whom they have an attachment relationship (Cozolino, 2002). The caregiver who is supposed to be a haven of safety is now understood as a threat. Consequently, the child is traumatized and is unable to experience a healing interaction with their caregiver, which heightens the negative impact (Cozolino, 2002).

A correlation has been made between adults who have been classified as unresolved/disorganized in their state of mind in regard to attachment and unresolved memories or trauma or loss. This correlation goes one step further in that adults who have an unresolved state of mind in regard to attachment have a higher likelihood of having children with a disorganized attachment style (Hesse & Main, 2000; Liotti, 2004). This association has caused concern for clinicians in that adults who suffer from trauma and have unresolved attachment are likely to form a problematic relationship with their children around their attachment, which will most likely lead to disorganization and a negative internal working model (Liotti, 2004).

The attachment relationship between caregiver and child in which the caregiver has unresolved trauma increases the likelihood that the child will experience trauma, which will also remain unresolved. Individuals who have unresolved trauma and a disorganized or disoriented attachment style are at higher risk for the development of psychiatric disturbances and mental

health problems (Siegel, 1999). Clinicians must have awareness of this issue and implement interventions directed towards resolving the trauma for the present and future generations (Siegel, 1999).

Methods

Research Design

The purpose of this exploratory research study was to further investigate practitioner perspectives on play therapy as an intervention with children who have experienced trauma, PTSD symptoms, and a co-morbid mental health diagnosis. This study aimed to gather prospective data utilizing a cross-sectional research design. The research design consisted of a survey that included both quantitative and open-ended questions.

Sampling

Three agencies in the Minneapolis/St. Paul metro area that serve early childhood mental health clients were recruited for participation. A contact person from each agency served as the agency representative to ensure anonymity among potential participants. This study utilized a convenience sample intending to reach a targeted sample size of approximately 50 respondents. The target population for this study was mental health professionals who provide service to an early childhood population. Prospective respondents had a background in Social Work, Marriage and Family Therapy, Professional Counseling, and Early Childhood Mental Health. Respondents who did not meet adequate credentials were not included in the sample. Persons under the age of 18 were also excluded from the sample.

After each agency granted approval, the agency representative distributed the survey to potential participants via e-mail. E-mail was drafted and distributed to potential participants via their employment agency's representative that included a link to the online survey. The contents of the e-mail included general information about the study. This e-mail also served as the consent form. Participants were informed that by selecting the link to the survey, they were providing their consent. The research questionnaire immediately followed.

Protection of Human Subjects

The target population for this research study was mental health professionals and they are not deemed as a vulnerable population. Participants received a consent form in their e-mail, which provided them with general information regarding the study. Participants chose to opt in to the study by selecting the link to the online survey; participants were also informed that by selecting the link to the survey they were providing their consent. Identifying information was not ascertained during the course of the survey, nor were participants asked to divulge any identifying information about the clients they serve.

The survey constructed for this research study contained very minimal or no risk. Participation in this study was entirely voluntary, as professionals were given the choice to opt in to the study. Research participants were not given an incentive for their participation. After carefully reading the information provided on the consent form in the e-mail, participants either accepted or declined their participation. Participants were allowed at anytime during the survey to exit without completing the survey without any imposed risk or repercussion. The survey for this research study was proposed and granted approval by the University of St. Thomas Institutional Review Board.

Measurement

The survey instrument distributed was created and developed by the principle investigator for this particular research study (Appendix A). The survey utilized a variety of questions to gather quantitative and qualitative data. Participants were asked about their experiences providing service to children who experienced trauma, exhibited PTSD symptoms, and have a co-morbid mental health diagnosis. Respondents also provided data regarding their experience with play therapy. This line of questioning included their identified theoretical model of play therapy, their beliefs on the effectiveness of the intervention, and their likelihood to

provide play therapy to populations that identify trauma, PTSD symptoms, and have a co-morbid diagnosis.

Analysis

Descriptive statistics are provided for each question set. Which provide frequencies, means, and standard deviations to describe participant responses. Inferential statistics (such as *t*-tests) are also used to make comparisons between groups. Tables and figures are provided to graphically represent the data analysis.

Findings

The following section describes the current research findings regarding participants' experience with trauma, PTSD, co-morbid disorders, and play therapy. First, participant characteristics and credentials are highlighted. Next, respondent's reasoning for selecting play therapy for treatment and frequency of use are presented. Which is followed by the effectiveness of play therapy as an intervention, specifically when treating complex trauma and PTSD symptoms when coupled with co-morbid disorders. Lastly, respondents express their thoughts about play therapy, trauma, and PTSD in the context of working with their child clients.

Participants

Two agencies that serve early childhood mental health clients agreed to participate in the survey. Due to the anonymity of participants, the number of distributed surveys by each agency representative is unknown. This survey gathered data from a sample of 22 respondents.

Participants were asked about their education level and their job titles.

Table 1

| <i>Education Levels</i> | | |
|-------------------------|----------|----------|
| Degree Attained | <i>N</i> | <i>%</i> |
| Bachelors | 1 | 5% |
| Masters | 15 | 68% |
| Doctorate | 6 | 27% |

As shown in Table 1, all respondents attained a college degree and the majority attained an advanced degree (e.g., Masters, Ph.D., Psy.D.). A variety of job descriptions/titles were represented (Table 2), with Therapists and Psychologists being the most common among the sample. Participants were allowed to report on more than one aspect of their job.

Table 2

| <i>Role at Work</i> | | |
|----------------------------|----------|----------|
| | <i>N</i> | <i>%</i> |
| <u>Job Description</u> | | |
| Therapist | 9 | 41% |
| Psychologist | 8 | 36% |
| Mental Health Professional | 3 | 14% |
| Supervisor/Director | 3 | 14% |
| Case Manager | 2 | 9% |
| Social Worker | 2 | 9% |

Table 3 displays respondent caseloads. The average caseload among respondents was 16 clients ($SD = 7.87$); although a wide range of caseloads were reported, ranging from 3 to 35.

Table 3

| <i>Typical number of clients</i> | | |
|----------------------------------|----------|----------|
| Caseload | <i>N</i> | <i>%</i> |
| Less than 10 | 4 | 18% |
| 10-15 | 5 | 23% |
| 15-20 | 10 | 45% |
| 20 or more | 7 | 32% |

Nearly all participants who responded to the question had experience with clients who sustained a single-event trauma (Table 4).

Table 4

History of providing services to children who have experienced trauma/PTSD

| Type of Trauma | <i>N</i> | % |
|---------------------|----------|------|
| Single-Event Trauma | 18 | 90% |
| Complex Trauma | 20 | 100% |
| PTSD Symptoms | 19 | 100% |

All respondents who elected to answer the question indicated that they had experience with clients who had been exposed to complex trauma. Likewise, all respondents indicated that they had experience with clients who exhibit PTSD symptoms (Table 4).

Table 5 shows that although all participants had been exposed to play therapy, none of the participants were registered play therapists.

Table 5

Exposure to play therapy and incidence of being registered

| | <i>N</i> | % |
|----------------------------------|----------|------|
| <u>Exposed to Play Therapy</u> | | |
| Yes | 20 | 100% |
| <u>Registered Play Therapist</u> | | |
| No | 22 | 100% |

Out of those exposed to play therapy, Table 6 shows that there were many different models and combinations of models were used. At least half of the respondents used non-directive (82%), child-centered (64%), directive (55%) and cognitive behavioral (50%) models.

Table 6
Types of theoretical play therapy models used

| Theoretical Play Therapy Models | N | % |
|---------------------------------|----|-----|
| Non-Directive | 18 | 82% |
| Child-centered | 14 | 64% |
| Directive | 12 | 55% |
| Cognitive Behavioral | 11 | 50% |
| Psychoanalytic | 7 | 32% |
| Group | 4 | 18% |
| Filial | 2 | 9% |

Group (18%) and Filial (9%) represent the models implemented less frequently.

Participants were asked about treating children with PTSD symptoms and a co-morbid disorder. When asked to select the co-morbid disorder for which they were most likely to use play therapy, a variety of disorders were identified (Table 7).

Table 7

Frequency of play therapy use with co-morbid disorders

| Co-morbid Disorders | N | % |
|---------------------------------|----|-----|
| Anxiety | 17 | 77% |
| Adjustment | 16 | 73% |
| Separation Anxiety | 14 | 64% |
| Attention Deficit Hyperactivity | 13 | 59% |
| Depressive | 12 | 55% |
| Conduct | 11 | 50% |
| Major Affective | 8 | 36% |
| Phobic | 8 | 36 |
| Dissociative | 5 | 23 |

The most common co-morbid disorder for which play therapy was used was anxiety (77%), followed by adjustment (73%), separation anxiety (64%), attention deficit hyperactivity disorder (59%), depressive (55%), and conduct disorder (50%). Very few participants would use play therapy when the co-morbid disorder was a dissociative disorder (23%).

Frequency of play therapy use and effectiveness

Overall, the majority of participants indicated that they provide play therapy frequently to their child clients. Approximately two thirds (66%) of participants reported that they provide play therapy to their child clients on a very frequent or somewhat frequent basis. (Table 8)

Table 8

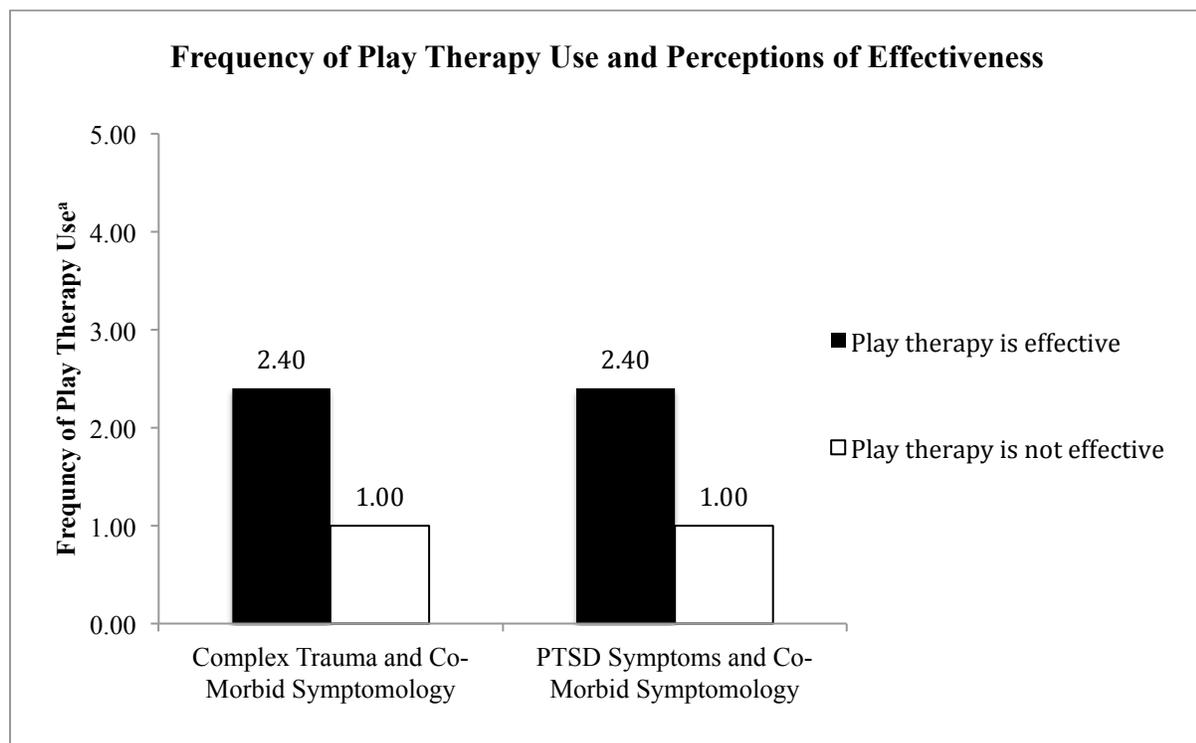
Frequency of play therapy use with child clients

| Frequency of Use | <i>N</i> | % |
|-----------------------|----------|-----|
| Very frequently | 8 | 44% |
| Somewhat frequently | 4 | 22% |
| Neutral | 3 | 17% |
| Somewhat infrequently | 1 | 6% |
| Very infrequently | 2 | 11% |

The frequency of play therapy use was compared between participants who did ($n = 15$) and did not ($n = 3$) believe play therapy was an effective intervention for children who have experienced complex trauma and a co-morbid disorder. Those who believe play therapy was an effective intervention used it more frequently ($M = 2.40$, $SD = 1.40$) than those who did not believe it was effective ($M = 1.00$, $SD = 0.00$). An independent samples t -test was conducted to compare, those who believed play therapy was an effective intervention to those who did not believe play therapy was an effective intervention. The difference between the two groups was statistically significant [$t(16) = 3.86$, $p < .05$] (Figure 1).

The frequency of play therapy use was also compared between participants who did ($n = 15$) and did not ($n = 3$) believe play therapy was an effective intervention for children who have experienced PTSD symptoms and a co-morbid disorder. Those who believe play therapy was an effective intervention used it more frequently ($M = 2.40$, $SD = 1.40$) than those who did not believe it was effective ($M = 1.00$, $SD = 0.00$). An independent samples t -test was conducted to compare the two groups. The difference between the two groups was statistically significant [$t(16) = 3.86$, $p < .05$] (Figure1).

Figure 1



Note: ^a Response scale to question: “How frequently have you provided play therapy to your child clients?”; 1 = Very Infrequently, 2 = Somewhat Infrequently, 3 = Neutral, 4 = Frequently, 5 = Very Frequently

Participants that believed play therapy was an effective intervention for treating children with complex trauma and who have a co-morbid disorder were more likely to use play therapy frequently. Likewise, participants that believed play therapy was an effective intervention for

treating children who have experienced PTSD symptoms and who have a co-morbid disorder were also more likely to use play therapy frequently. Given the results of this analysis, it can be presumed that those with comfort in the effectiveness of play therapy will more frequently utilize play as a modality for treating children whose complex trauma and/or PTSD is coupled co-morbidly with another mental health disorder(s). (Figure 1).

Treating children using play therapy

Participants were asked to comment on how play therapy could be used to treat children with complex trauma and a co-morbid disorder. Out of the 22 total respondents, 15 respondents selected to comment and their responses were thematically analyzed. Three major themes emerged; communication, safe space, and family involvement appear to be relevant issues to practitioner's regarding play therapy.

Communication. Majority of participants discussed the idea of communication when using play therapy with their child clients. The theme of communication appeared to be represented in two ways. The first way is in children using play for the identification and expression of their needs and feelings. The following participant describes his/her experience with communication in play therapy.

Often, play is the way that children communicate their feelings and thoughts. It is a great way to get at children's thoughts and feelings if they are struggling or not able to communicate verbally.

Another practitioner speaks to children using play as their form of communication.

Through play children can express what is most on their minds. It can be helpful in identifying feelings, thoughts and worries.

Numerous practitioners stated that they believe play therapy is necessary in the treatment of trauma and co-morbid disorders as it is the only therapy that is age appropriate for children. One practitioner describes that idea,

Play therapy allows for the expression of emotion and narration of concerns in a language that is age-appropriate and more accessible than talk therapy is for many children.

As previously mentioned, the second way communication is represented was by children re-enacting their trauma and creating their trauma narrative. Children who have experienced trauma and may have PTSD may use their play to re-enact their trauma. This quote illustrates a practitioners experience with children who re-enact their trauma in play.

Play is often the only way a younger client can communicate complex feelings and experiences. Through play, a child is able to show what happened to them, and in this way hopefully gain clarity, insight, normalization, and the sense that another situation would not have to end the same way.

Another practitioner speaks to children communicating their trauma experience while at the same time facing challenges brought on by the child's co-morbid mental health diagnosis.

I feel play therapy provides a safe place for children to process trauma, play out what they have experienced and develop strategies for managing a co-morbid disorder.

Practitioners are able to use play therapy to treat children with complex trauma and co-morbid disorders through the vein of communication that play therapy inspires. Through play, children are able to identify and express their feelings to the practitioners who can define, frame, and provide emotional support for the child. Another major aspect of communication in play therapy is the sharing of their trauma. When children are able to communicate their trauma

through play, the practitioner becomes informed and is better able to provide insight, understanding, and a framework for how not all relationships that the child has will involve traumatic situations and some relationships can be safe and trusting.

Safe space. Safe space was another theme that emerged from the analysis. Specifically, a safe 'place' space referred to creating an environment safe for play and exploration as well as for building relationships. The idea of play therapy is that the practitioners who utilize it to treat trauma and co-morbid disorders create that safe space. The safe space is not only represented by the physical environment of the playroom but also created by the relationship between the practitioner and the child. One practitioner describes how a constructing a safe space for the child allows them to benefit from play therapy as a treatment intervention.

Play provides the child with a safe psychological distance from their trauma while still allowing exploration of both their trauma(s) and comorbid symptoms.

The following quote speaks to the challenges that a child faces when dealing with a co-morbid disorder and how a safe place in play therapy can be a place for learning and resolution.

Many children experience complex trauma and don't meet criteria for PTSD but instead experience anxiety, depression, issues with self-regulation and conduct issues. Play therapy provides them with a safe space to process their traumatic experiences, learn to tolerate/modulate affect, learn to name feelings and create a narrative.

Family Involvement. A few practitioners spoke to how involving the child's family in the play can even further the benefits when using play therapy to treat trauma and co-morbid disorders. One practitioner shared his/her experience.

My favorite way to use play is with families (typically parent-child dyads) in order to provide opportunities to repair and improve strained relationships and help parents connect to their children in different ways.

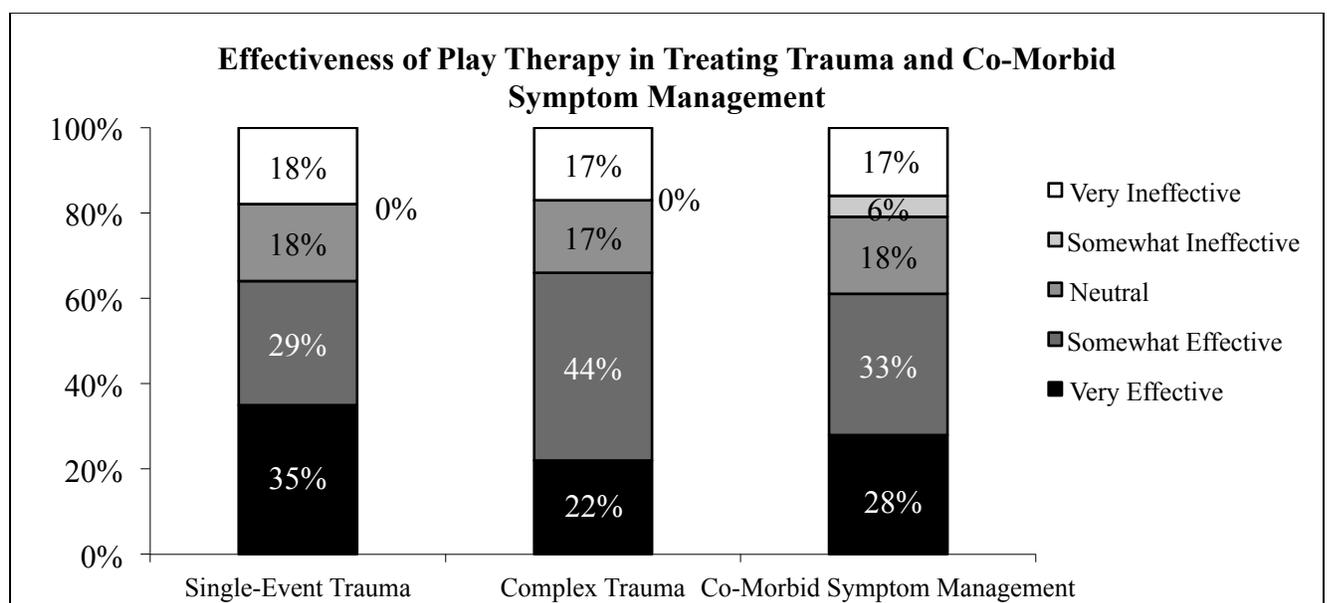
Overall, majority of the practitioners sampled expressed numerous benefits to the use of play therapy as an intervention in treating trauma and co-morbid disorders in children. An example of some of the benefits is expressed in the quote below.

I have utilized play therapy in a variety of ways to address trauma and related conditions. It has been helpful for teaching and practicing coping strategies, learning to problem-solve, enhancing feelings of safety, creating trauma narratives, and helping the child communicate their needs and perceptions.

The effectiveness of play therapy

The majority of respondents believe that play therapy was very effective or somewhat effective in treating symptoms of a single-event trauma, complex trauma, and in co-morbid symptom management (Figure 2).

Figure 2

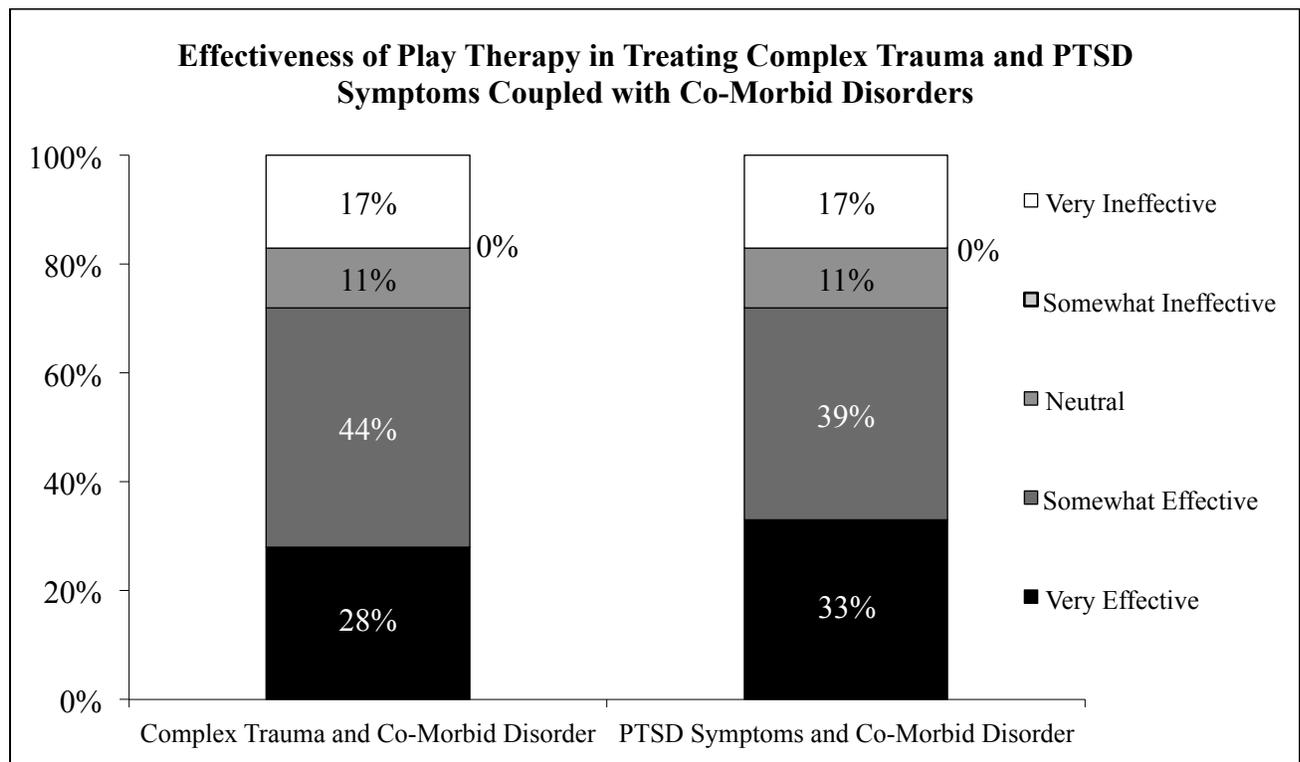


The highest percentage of respondents (35%) indicated that play therapy was very effective in treating single-event trauma and the lowest percentage of participants indicated that play therapy was very effective in treating symptoms of complex trauma (22%).

The effectiveness of play therapy in treating complex trauma and PTSD symptoms when coupled with co-morbid disorders

Play therapy was considered an effective intervention among participants, for children who experienced a complex trauma and also a co-morbid disorder. As seen in Figure 3, 72% of respondents reported that play therapy was a very or somewhat effective intervention. Likewise, 72% of respondents also believed that play therapy was considered an effective intervention for children with PTSD and a co-morbid disorder.

Figure 3



However, slightly higher percentage of participants believed play therapy was a very effective intervention when treating PTSD and a co-morbid disorder (33%) than those who reported it was very effective in treating a complex trauma and a co-morbid disorder (28%).

Recognizing co-morbid symptomology and creating a felt sense of security

In general, most respondents were confident in their abilities to recognize co-morbid symptomology in children with PTSD symptoms (Figure 4). Over half (56%) of respondents strongly agreed with the statement “I am confident that I can recognize co-morbid symptomology in children with PTSD symptoms.”

Figure 4

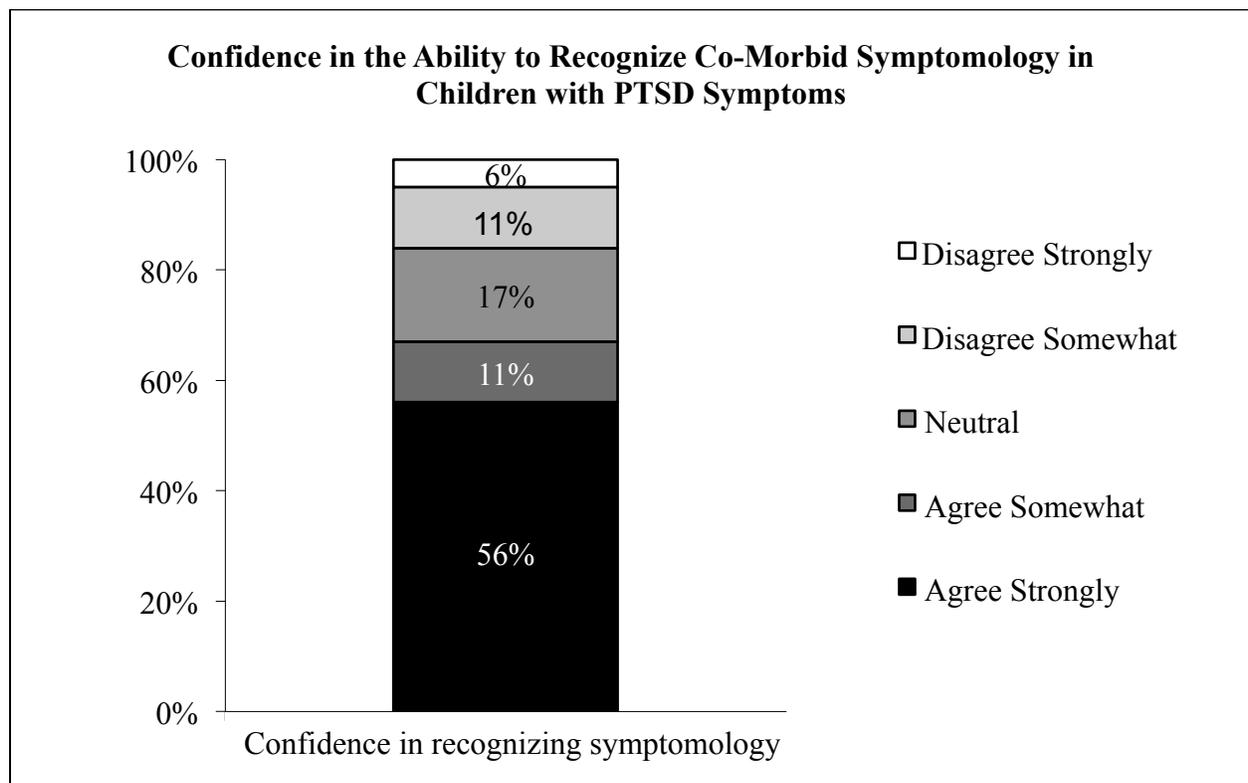
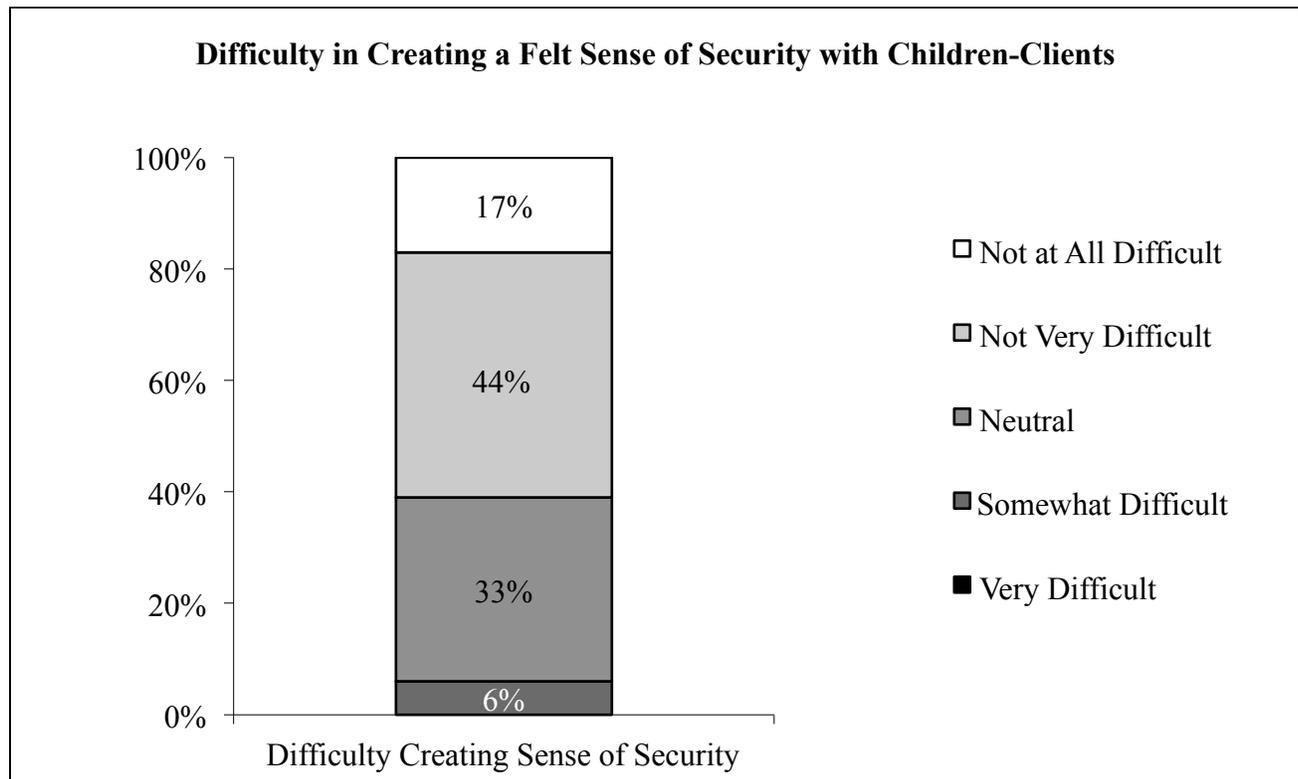


Figure 5 presents participants’ perceived difficulty with creating a felt sense of security with their child-clients. Forty-four percent reported that creating a felt sense of security was not

very difficult. Few respondents indicated that this was not at all difficult (17%) and no participants indicated that this was very difficult (0%).

Figure 5

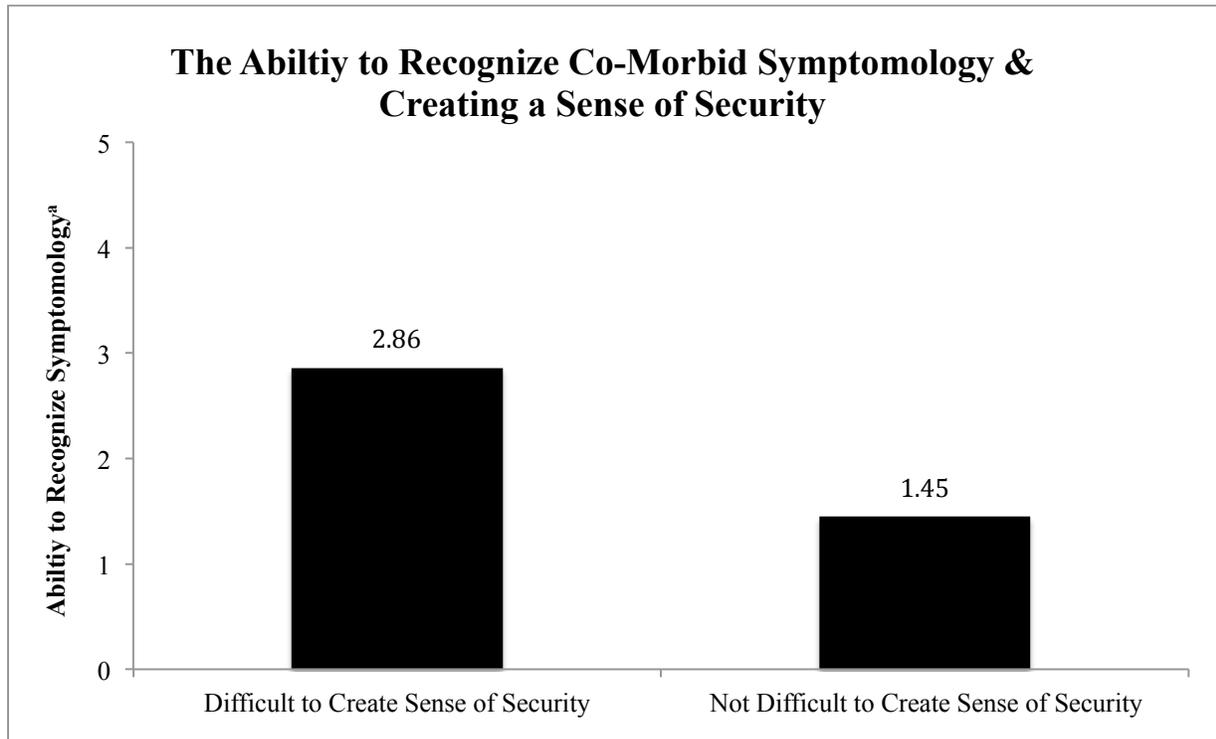


Confidence in the ability to recognize co-morbid symptomology in children with PTSD symptoms was assessed between two groups: participants who did not believe it was difficult to create a felt sense of security and those who did believe it was difficult. An independent samples *t*-test was conducted to compare the two groups.

As displayed in Figure 6, participants who believed it was difficult to create a felt sense of security were less confident that they could recognize co-morbid symptomology in children with PTSD symptoms ($M = 2.86, SD = 1.35$) than those who did not believe it was difficult ($M = 1.45, SD = 1.04$). The difference in confidence levels reached statistical significance [$t(16) = 2.35, p < .05$]. Results from this analysis suggest that there is a linkage between being confident

in recognizing co-morbid symptomology and the belief that it is difficult to create a felt sense of security.

Figure 6



Note: ^a Response scale to question: “Rate your agreement with the following statement: I am confident that I can recognize co-morbid symptomology in children with PTSD symptoms.” 1 = Strongly Agree, 2 = Agree Somewhat, 3 = Neutral, 4 = Disagree Somewhat, 5 = Disagree Strongly

Practitioner’s thoughts regarding play therapy, complex trauma or PTSD

Practitioners were asked to share any final thoughts or opinions at the end of the survey regarding play therapy, complex trauma, or PTSD. Out of the 22 respondents, 9 practitioners expressed personal and professional thoughts and opinions regarding the topic. All 9 practitioners spoke about play therapy. A very clear theme emerged when thematic analysis was done on all participant responses; a theme of play being a crucial element in the therapy process

with young clients was evident. The following quote sums up this point and allows insight into one practitioner's experience.

With very young children I feel that play is an essential tool in the therapy process - it is how children explore, develop, and communicate and relate. When children have only pre-verbal memories of trauma (due to their young age and/or dissociation) play allows exploration of their experience when other modalities cannot. I love play therapy:).

Another practitioner speaks to play being age appropriate for the client.

For younger children with PTSD, play therapy may be the only effective option for treating symptoms of trauma (they're not likely to sit down and discuss it!).

Finally, through play, practitioners are able to connect their child clients to their caregivers by opening the door for communication and understanding.

Play therapy is one of my most frequently used interventions. I find that it is a helpful tool for understanding the child and facilitating communication between children and their caregivers.

It is apparent that the practitioners who participated in this current research consider play therapy to be an effective intervention. Practitioners use play therapy with a variety of child clients and identify that it is a useful modality when treating children with trauma histories, PTSD symptoms, and co-morbid mental health diagnoses. The data collected and themes that emerged will be discussed, and compared to previous literature.

Discussion

The purpose of this study was to explore practitioners' perspectives on play therapy as an intervention when used with children who have experienced trauma, have PTSD symptoms, and a co-morbid mental health diagnosis. Information was gathered from practitioners via an anonymous survey. Findings from this study support past research in this area as well as provide new information.

Overall, the results indicate that practitioners believe that play therapy is an effective intervention when treating children with trauma histories, PTSD symptoms, and mental health disorders. They believe that it is effective in treating each of these issues individually as well as when they occur concurrently. Practitioners generally used play therapy frequently (66%). Likewise, the more effective participants believed play therapy was, the more frequently they were to implement it as an intervention. The majority of participants believe that play therapy is effective in treating symptoms of single-event trauma (64%), complex trauma (66%), and co-morbid symptom management (61%) individually. However, practitioners continued to believe that play therapy is an effective intervention when these symptoms occurred concurrently. Seventy-two percent of practitioners believe that play therapy is an effective intervention when complex trauma symptoms and a co-morbid disorder are both present. Similarly, 72% of participants believe that play therapy is effective when applied to the treatment of PTSD symptoms and a co-morbid disorder.

Practitioners' sentiment of the effectiveness of play therapy is in agreement with prior research in this area. Play therapy was found to be very effective and beneficial to children with mental health concerns. Landreth (2002) reports that play therapy is an effective intervention with children of all diagnostic categories; meaning that there are only very limited times in

which one would caution on placing children in play therapy. Schaefer (1994) asserts that play therapy has been accepted as an effective intervention to utilize with children who have been exposed to trauma. Ray, Bratton, Rhine, and Jones (2001) found play therapy to be an effective intervention in the field of child psychotherapy and that it remained effective regardless of the setting, modality, age, gender, and theoretical school of thought. These results assert that play therapy is an effective intervention to implement with children who have experienced complex traumatic events. Similarly, research shows that play therapy would be an effective intervention to implement with PTSD as it is a trauma-related disorder, especially considering the positive correlation between the exposure to trauma and the trajectory of developing PTSD (van der Kolk, 2005).

Results of this study are also consistent with research on play therapy effectiveness with mental health disorders. Research shows that play therapy is effective in decreasing anxiety and depression symptoms, decreasing separation anxiety symptoms, and improving ADHD symptoms (Baggerly, 2004; Milos & Reiss, 1982; and Ray, Schottelkorb, & Tsai, 2007). This shows that play therapy is effective in the symptom management of mental health disorders. Practitioners from the current study concur with these findings, they also believe that play therapy remains an effective intervention when the mental health disorder occurs concurrently with a trauma-related disorder. This finding is supported by the research that co-morbid PTSD occurs more frequently than non-comorbid PTSD (Copeland *et al.*, 2007; Macdonald *et al.*, 2010; & Silverman *et al.*, 1996).

Practitioners of the current study were asked to identify the theoretical models of play therapy that they use with their clients who have trauma exposure, PTSD, and co-morbid disorders. Non-directive and child-centered play therapies were both used by more than half of

participants in the treatment of symptoms. This is congruent with previous research in that numerous studies evaluating play therapy in the treatment of mental health disorders implemented child-centered play therapy (Baggerly, 2004 & Ray *et al.*, 2007). As reported by Landreth (2002), there are similarities between the two models (child-centered and non-directive), in that they both allow the child to control the direction of the play. When asked about the co-morbid disorders that they treat with play therapy, practitioners in the current study identified anxiety, adjustment, separation anxiety, ADHD, and depressive disorders as most common. Past research has identified each of these mental health disorders having successful treatment rates with play therapy (Baggerly, 2004; Milos & Reiss, 1982; and Ray, Schottelkorb, & Tsai, 2007).

The current research identified themes regarding how practitioners use play therapy as a treatment intervention. A theme of communication was discovered, complimented by a theme of age-appropriateness. Numerous practitioners stated that play is the way in which young children communicate their thoughts and feelings as they are unable to engage in typical talk therapy used with adults. This is supported in previous research as Landreth (2002) stated that children do not have the verbal skills or the cognitive capacity to engage in talk therapy. Instead play is their preferred means of communication (Davenport & Bourgeois, 2008; Landreth, 2002; Gil, 1991; Norton & Norton, 1997; Schaeffer, 1994).

Another theme that emerged in the current research regarding play therapy implementation is that of a safe space. Practitioners identified the need for children to feel that they are in a safe space in order to reenact their trauma and work on their emotional/behavioral issues from their co-morbid disorder. This aligns with previous research on play therapy. According to Van der Kolk (2003), establishing a safe environment with clear boundaries is

essential. This is a crucial step in the beginnings of treating children with play therapy.

Practitioners in the current study were also asked about the level of difficulty in creating a felt sense of security with their child clients. The majority of clients indicated that creating a felt sense of security for their clients was not difficult (61%). Interestingly, the current study found that practitioners who identified difficulty in creating a felt sense of security with the child clients were less confident in their abilities to recognize co-morbid symptomology in the children with PTSD. Previous research asserts the importance of the child having a sense of safety, trust, and security in the environment and in interactions with the therapist (Gil, 1991).

Strengths and Limitations

The current research study presents with numerous strengths; however, also possess some limitations. The research design used a convenience sample that is small, which limits ability for conclusions to be generalized to a larger population. One of the largest limitations of this research is that the play therapy intervention and its impacts on trauma, PTSD symptoms, and co-morbid symptoms are not being measured directly. The survey questionnaire was designed specifically for this study and has not been field tested, which may affect the validity of the instrument. Mental health professionals may utilize a different intervention based on their comfort level with their own intervention skills. Therefore, the questions that ask for opinions on the effectiveness of play therapy may introduce a confounding variable. Another limitation is that the analysis was limited due to the lack in variability in responses from practitioners.

There are also strengths to the current research. This study allows data to be gathered on a vulnerable population without direct contact. Because subject matter experts are the participants of this study, data gathered is expected to be credible. Furthermore, the methodology allows for participant information and responses to remain anonymous. One of the strengths of

this study is that participant expertise with play therapy was prevalent. Likewise, practitioners had ample experience working with children who have been traumatized, have PTSD, and co-morbid symptomology, providing credibility to the data collected. These strengths and limitations inform how the findings of this survey inform social work practice and research.

Implication for Social Work Practice

Current findings allow for reflection as to how social work practice can be informed regarding trauma, PTSD, and play therapy. Practitioners reported the support for the effectiveness of play therapy in the treatment of trauma related symptoms, PTSD symptoms, and co-morbid mental health symptomology. This continues to support past research done on the validity of play therapy as an intervention in terms of application to treating trauma or mental health disorders. An implication for practice from this finding, is that adequate training in using play therapy as an intervention needs to occur within the practitioners' education or employment setting to ensure a high confidence level in implementing play therapy with this certain population of clients. Without proper training, practitioners may not have the confidence to utilize the intervention; therefore, children who would benefit from it will not receive it as a treatment intervention. Practitioners in the current study identified that they felt confident in their abilities and were empowered to use it with their clients. This is extremely beneficial for the child clients as they get to reap the benefits of being treated with an effective intervention strategy.

Another implication for social work practice that stems from the findings is practitioners' ability to recognize co-morbid symptomology. Previous research stresses the importance of proper diagnosis and treatment based on the specific symptoms each child presents. Part of being able to accurately diagnose and treat is being able to recognize PTSD symptoms apart from

symptoms from a co-morbid mental health disorder. It is crucial that practitioners gain skills and confidence in providing diagnosis, utilizing differential diagnosis procedures, as well as gain familiarity with diagnostic assessment tools.

The idea of a safe space is another implication for social work practice. Practitioners identified creating a safe space and a sense of security with their clients as a vital part in the therapeutic process. The relationship that is created between the therapist and the child client is crucial to the treatment outcomes for the child. Social work operates from the person-in-environment perspective in which practitioners are encouraged to meet their clients where they are and consider all aspects of their environment when working with them. Therefore, practitioners must allow the child to be their partner and lead them in the creation of a safe space in which treatment can occur. Practitioners can be preemptive in the creation of the safe space as well, allowing the child a high level of comfort in an obviously uncomfortable time for them.

Implications for Social Work Research

Findings from the current research may be used to inform on play therapy as an intervention. They may be implemented into education programs or employment trainings by relaying what experts in the field think about play therapy as an intervention. Specifically when applied to child populations with trauma histories, PTSD, and co-morbid diagnoses. Results may also be used to educate practitioners on the importance of being able to recognize co-morbid symptoms in children who present with PTSD. As previously stated, the accurate identification, diagnosis, and treatment of any and all mental health concerns in children is vital to their outcomes.

Due to the limitations of this study, there are multiple areas where future research can continue to inform us. The current study gathered information from practitioners, future research

could be expanded by conducting a more controlled study by evaluating the intervention of play therapy directly with complex trauma and PTSD. Previous research indicates that play therapy is effective with a variety of mental health disorders; however, little is known about how effective play therapy is when these mental health disorders occur concurrently with PTSD. Studies could be done specifically focusing on anxiety, depressive, adjustment, or separation anxiety disorders as these were identified to occur frequently as co-morbid disorders to PTSD.

Another implication for research surrounds the idea of practitioners creating a safe space for their clients using play therapy. It would be beneficial for practicing practitioners, new practitioners, as well as family members of the child who is receiving play therapy to know how the safe space is created. By defining what a safe space is and then providing information on how to create it will provide clarity to all involved in the process. Also, how does the creation of a safe space and sense of security in the child affect the effectiveness of the play therapy intervention?

Finally, there is a gap in research surrounding play therapy as an intervention when PTSD and a co-morbid mental health disorder are present. Previous research highlights the effectiveness of play therapy with PTSD and then also with a myriad of mental health disorders; however, there is limited research providing data on the effectiveness of play therapy when the two occur concurrently. Closing this gap in research would be beneficial to the field of social work and will positively inform the practitioners that work in early intervention settings.

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Appendix A

About You...

1. What is your highest education level?

- | | |
|---|--|
| <input type="checkbox"/> High school or equivalent | <input type="checkbox"/> Master Degree |
| <input type="checkbox"/> Some College, No Degree Acquired | <input type="checkbox"/> Ph.D. |
| <input type="checkbox"/> Associates Degree | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Bachelor Degree | |

2. Are you a registered play therapist? Yes No

3. What is a broad description of your role at work? (e.g., therapist, social workers, psychologist, mental health professional etc.) _____

4. What is the size of your typical client caseload? _____ Clients

Your Experience with Children Who Have Experienced Trauma

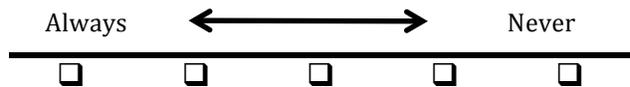
1. Have you provided service(s) to children who have...

a. Experienced a single-event trauma Yes No
(one isolated occurrence)

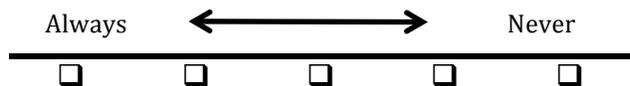
b. Experienced complex trauma Yes No
(pervasive, chronic exposure to trauma)

c. Exhibited PTSD symptoms Yes No
(if no, skip to "In the Future")

2. Children who have been exposed to complex trauma often have a co-morbid mental health diagnosis.



3. Children who exhibit PTSD symptoms often have a co-morbid mental health diagnosis.

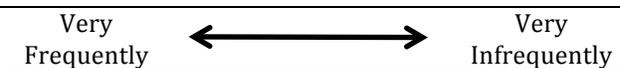


Your Experience with Play Therapy

1. Have you been exposed to play therapy as an intervention in your academic study? Yes No
(if no, skip to end of survey)

2. From which play therapy theoretical model(s) do you operate? *(select all that apply)*

- | | | |
|---|---|--|
| <input type="checkbox"/> Psychoanalytic | <input type="checkbox"/> Child-centered | <input type="checkbox"/> Directive |
| <input type="checkbox"/> Filial | <input type="checkbox"/> Cognitive Behavioral | <input type="checkbox"/> Non-Directive |
| <input type="checkbox"/> Group | <input type="checkbox"/> I do not know | |



3. How frequently have you provided play therapy to your child clients?

4. Overall, how effective has play therapy been in...

| | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | Very Effective | ←————→ | | | Ineffective |
| a. Treating symptoms of single-event trauma | <input type="checkbox"/> |
| b. Treating symptoms of complex trauma | <input type="checkbox"/> |
| c. Co-morbid symptom management | <input type="checkbox"/> |

5. How effective is play therapy as an intervention for children

| | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | Very Effective | ←————→ | | | Ineffective |
| a. who have experienced complex trauma and who also have a co-morbid disorder? | <input type="checkbox"/> |
| b. with PTSD who also have a co-morbid disorder? | <input type="checkbox"/> |

6. How difficult is it to create a felt sense of security with your child clients?

| | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | Very Difficult | ←————→ | | | Not Difficult |
| | <input type="checkbox"/> |

7. Please rate your agreement with the following statements:

| | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | Strongly Agree | ←————→ | | | Strongly Disagree |
| a. I often treat children who have experienced complex trauma using play therapy. | <input type="checkbox"/> |
| b. I often treat children with PTSD using play therapy. | <input type="checkbox"/> |
| d. I am confident that I can recognize co-morbid symptomology in children with PTSD symptoms. | <input type="checkbox"/> |
| e. Play therapy is an effective intervention to address PTSD symptoms and the co-morbid symptoms concurrently. | <input type="checkbox"/> |

8. Assume you are treating a child with PTSD symptoms and a comorbid disorder. Please select the disorder(s) in which you are most likely to use play therapy as an intervention? *(Select all that apply)*

- Adjustment
- Depressive
- Major Affective
- I don't feel qualified to answer this question
- Attention Deficit Hyperactivity
- Conduct
- Dissociative
- Anxiety
- Phobic
- Separation Anxiety

In the Future...

1. If you were providing services to children, would you consider play therapy as an intervention? Yes No

2. If you were to work with a client who had PTSD and symptoms from a co-morbid disorder, would you consider play therapy as an effective intervention? Yes No

Your Opinion...

1. How can play therapy be used to treat children with complex trauma and a co-morbid disorder?

2. Please use the space below to write any further thoughts or opinions regarding play therapy, complex trauma or PTSD.
