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Play therapy with victims of child abuse

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Abstract

Child abuse is a very serious issue around the world. An estimated 906,000 children were determined to be victims of child abuse or neglect in the United States in 2003. Child fatalities are the most tragic consequence of maltreatment. Play therapy provides children with the ideal environment where they feel safe and they may experience their feelings without restriction.

Oftentimes play allows children to distance themselves from experiences that are quite painful if expressed directly to a therapist. When assessing the needs of children, it is important for play therapists to assess the phenomenological impact of the abuse, the family's level of dysfunction, the environmental stability, the age of the child, and the child's relationship to the offender.

PLAY THERAPY WITH VICTIMS OF CHILD ABUSE

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Child abuse is a very serious issue around the world. An estimated 906,000 children were determined to be victims of child abuse or neglect in the United States in 2003. Child fatalities are the most tragic consequence of maltreatment. Play therapy provides children with the ideal environment where they feel safe and they may experience their feelings without restriction. Oftentimes play allows children to distance themselves from experiences that are quite painful if expressed directly to a therapist. When assessing the needs of children, it is important for play therapists to assess the phenomenological impact of the abuse, the family's level of dysfunction, the environmental stability, the age of the child, and the child's relationship to the offender.

For several years, professionals have been interested in the process of therapy with children (Kottman, 2001). According to the Association for Play Therapy (1997) play therapy is defined as the "Systematic use of theoretical model to establish an interpersonal process in which trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development" (p. 4).

Play therapy is based on the reality that play is the child's instinctive way of expression (Gil, 1991). Axline (1974) asserted that "Children often "play out" their difficulties in therapy, whereas adult clients are more prone to "talk out" their problems" (p. 9). Play encourages children to deal with feelings that are upsetting, allowing them to better manage their emotions (Ablon, 1996).

Another way to view play therapy is to see it as "an approach to communicating therapeutically with clients using toys, art materials, games, and other play media, providing clients with a safe and nurturing relationship in which they can explore and express feelings" (Kottman, 2001, p. 1). According to Kottman (1990), play therapy is often chosen over other types of "talk therapy," as children do not often have the words to discuss what is bothering them, or what is currently going on in their lives (Kottman, 1990). During play therapy, most of what the child does relates to metaphoric communication about the relationships in a child's life (Kottman, 2003).

Bratton and Ray (2000) generated the results of more than 100 case studies noting the usefulness of play therapy as an intervention with abused children. In these studies, the participants displayed high levels of positive behavior and decreased levels of symptomatic behavior after the therapy ended. Consequently, these studies provide support for the effectiveness of play therapy as an intervention for abused children with the following issues: social maladjustment, anxiety and fear, negative self-worth, and physical or learning disabilities (Bratton & Ray, 2000).

Child abuse is a worldwide problem worthy of discussion (Children Today, 1992). Many states separate child abuse into subcategories including physical abuse, sexual abuse, and neglect (Gil, 1991; Kharti, 2004). Abuse may be a source of trauma for many children (Monahon, 1993). Children who are victims of this kind of violence typically develop various signs of trauma, including post-traumatic stress (Monahon, 1993). Play therapy is a practical treatment intervention for children who are victims of child abuse (Gil, 1991; Kottman, 2001; Kottman, 2003b).

Although play therapy has often been held in high esteem as an effective type of child therapy, the meaning and significance have not always been agreed upon by therapists. According to Schaefer (1983):

> It is somewhat difficult for anyone interested in play and play therapy to gain a clear understanding of what is meant by the term play because no

single, comprehensive definition of the term has been developed. However, the potential benefits of play are well documented (p.2).

In previous years, several therapists have questioned whether play encourages structural change, pointing to the vague quality of play (Sandler, Kennedy, & Tyson, 1980; Gil, 1991). Although play therapy has its critics, it has proven to be a valid type of child therapy. Researchers such as Axline (1947; 1974), Gil (1991), Kottman (2001; 2003a; 2003b) and Landreth (1991; 2002), have all found play therapy to be a very reliable and appropriate form of treatment, especially for victims of childhood abuse and trauma.

Due to its validity, it is evident that play therapy is an important topic worthy of discussion. The current paper will discuss play therapy in more depth, including which clients are most appropriate for play therapy, the play therapy room, the history of play therapy, Child-Centered play therapy, and Adlerian play therapy. In particular, the paper will address various forms of child abuse, consequences of abuse, and applications of play therapy with abused children.

A Brief History of Play Therapy

In many ways, the history of play therapy reflects that of psychology (Richards, 1996). The term child therapy has often been used synonymously with play therapy (Gil, 1991). Sigmund Freud was the first therapist to uncover his client, Little Hans', unconscious fears and worries in 1909 (Gil, 1991). But according to Schaefer (1980), play therapy was not directly used until 1920 when

Hermine Hug-Hellmuth started utilizing play for the treatment and diagnosis of childhood issues. Then some 10 years later, Anna Freud, the famous daughter of Sigmund Freud, practiced psychoanalytic play therapy (Gil, 1991).

Psychodynamic play therapy was the first type of play therapy used with children (Gil, 1991). Psychodynamic play therapists focused on unconscious concerns and conflicts, believing that the substance present in a child's play is a way of understanding "intrapsychic" conflict and personality structures (Kottman, 2003b). In the late 1940's, Nondirective, Client-Centered play therapy emerged (Gil, 1991). This approached combined Carl Rogers's Client-Centered therapy for adults with many of the ideas of Virginia Axline and Garry Landreth (Kottman, 2001).

Axline (1947) believed that development and growth in a child occurs as a result of the relationship with the therapist, not as the result of specific techniques. She suggested that it is not appropriate to decipher the child's play or to praise his or her behavior. Some years later, Landreth (1991) expanded on Axline's ideas to develop Child-Centered play therapy. He believed that the play therapy relationship and environment must be distinctive from any other relationship or environment experienced by the child (Landreth, 1991). Landreth (1991) further believed that the therapist must function as a mirror for the child's feelings.

Cognitive-Behavioral play therapy is based upon the work of many of the early behaviorists and cognitive-behaviorists (Kottman, 2001). This therapy is

often viewed as structured, directive, and goal-oriented (Kottman, 2001). Behavioral techniques and cognitive strategies are combined with play to teach children novel ways of viewing themselves, their relationships, and their problems (Kottman, 2001).

Ecosystemic play therapy is based upon the theory of O'Connor (2000). This approach to play therapy proposes that play therapists shift their attention away from individual aspects of children's lives and take into account the many subsystems that have an effect on them. Only by understanding the influence of each system can a therapist understand a child's struggles (Kottman, 2001).

Listed above are a few major play therapy theories and a brief history of each theory. As previously mentioned, play therapy often resembles the theory and history of psychology (Richards, 1996). Many of the concepts that pertain to adult therapy are often applicable with the therapy of children, but the main difference is that play is used as opposed to the traditional method of "talk therapy" (Gil, 1991; Kottman, 1990; Kottman, 2001).

Child-Centered Play Therapy

Child-Centered play therapy is associated with the work of Garry Landreth, Virginia Axline, and Carl Rogers (Kottman, 2001). The Child-Centered viewpoint is a comprehensive philosophy for living one's life in contact with children (Landreth, 2002). This includes an intense commitment to certain attitudes about children and their inborn ability to move toward growth (Landreth,

2002). Landreth (2002) believed that "Children are the best sources of information about themselves. They are quite capable of appropriately directing their own growth, and they are granted the freedom in the play therapy relationship to be themselves in the process of playing out feeling and experiences" (p. 59). Landreth (2002) strongly believed in the inner person of the child. The therapist's goal is to connect with the child in ways that will encourage the child's personal healing power (Landreth, 2002).

Child-Centered play therapy is both a fundamental philosophy of the inborn tendency for children to work toward growth, and an attitude of strong belief in children's ability to be self-directing (Landreth, 2002). This progressing tendency is the central theme of Child-Centered play therapy (Landreth, 2002).

The Child-Centered play therapy approach helps children do several things, such as develop a more positive self-concept, assume greater self-responsibility, become more self-directing, become more self-accepting, engage in self-determined decision making, experience a feeling of control, and become sensitive to the process of coping (Landreth, 2002). According to Landreth (2002), play therapy impacts young clients' development by helping them accept themselves. Landreth (2002) further believed that the prospective learning experiences in play therapy are directly associated with the extent in which the therapist is successful in creating an environment of safety within which a child can feel safe enough to risk expressing their deepest feelings (Landreth, 2002).

Adlerian Play Therapy

Individual psychology, developed by Alfred Adler in the early part of the 20th century, is the basis of Adlerian play therapy (Kottman, 2003b). This theory presents a description of the nature of people (Kottnan, 2001). According to Kottman (2003b), Adler believed that people are socially embedded, goal directed, subjective, and holistic beings.

Furthermore, Adler believed that all people have a desire to belong (Kottman, 2003b). Adlerian play therapists must reflect on the child and the child's behaviors in the presence of other people, rather than in isolation (Kottman, 2003b). According to Kottman (2003a), play therapists must understand the purposes of the child's behaviors and distinct ways the child gains a sense of belonging and meaning. The major goals of Adlerian play therapy include helping clients to enhance their social interest, overcome their feelings of inferiority, make changes in their life goals, alter negative motivation, and gain a sense of equality with others (Kottman, 2003b). The role of the therapist is flexible, changing with the different phases of therapy (Kottman, 2001). The therapist is both directive and nondirective in approach (Kottman, 2003b).

There are four phases of the therapy process in Adlerian play therapy (Kottman, 2003b). These phases include: building a relationship, exploring the client's lifestyle, helping the client gain insight into his or her lifestyle, and reorienting and reeducating the client (Kottman, 2003b). In Adlerian play

therapy, the therapist goes through these four phases with the child during the play session and after the session with the parents during parent consultation (Kottman, 2003b). The stages of parent consultation greatly resemble those of Adlerian play therapy (Kottman, 2003b).

In the first phase, the therapist uses tracking, restatement of content, reflection of feelings, questions, active interaction, limit setting, and encouragement to establish an open relationship with the child (Kottman, 2003). In the second phase, the play therapist uses observation of play and other exchanges, questioning techniques, and art therapy strategies to examine the child's lifestyle (Kottman, 2003).

During the third phase, the therapist may use tentative hypotheses, interpretation, metaphors, art techniques, confrontation, immediacy, and humor to assist the child in inspecting his or her own attitudes, perceptions, thoughts and feelings (Kottman, 2003b). In the final phase, the therapist helps the child and parents use the choices in the play therapy sessions, in the family, and other outside settings. Practicing the recently obtained knowledge and skills in the session helps the child and parents combine what they have learned (Kottman, 2003b).

Directive versus Nondirective Play Therapy

Play therapy may be either directive or nondirective in form (Gil, 1991; Kottman, 2003b). The basic difference between these approaches is based upon

the therapist's involvement in therapy (Gil, 1991; Kottman, 2003b). Directive forms of play therapy include Theraplay, Ecosystemic, Cogntive-Behavioral, and Adlerian play therapy. Nondirective forms of play therapy include Child-Centered, Psychodynamic, Experiential-metaphorical, and Jungian play therapy (Kottman, 2003a).

In the directive form, the therapist may take on responsibility for leadership in the play therapy sessions (Axline, 1974). In this case, the play therapist generally chooses what the child should play with as well as the direction of the therapy session (Gil, 1991). Directive approaches are often short-term and symptom-oriented (Gil, 1991).

On the other hand, nondirective play therapy is nonintrusive, placing the responsibility with the child and letting him or her decide which direction the session will go (Axline, 1974). The child has the freedom to choose the toys he or she wants to play with (Gil, 1991). Nondirective therapists view the child often and report verbally what they see by the use of paraphrasing, tracking, reflecting content, and reflecting feelings. They also refrain from answering questions or providing directions (Gil, 1991).

In addition, a nondirective therapist may present a child with sufficient opportunities for art work, story telling, or puppet play, whereas a directive therapist might ask a child to draw a specific thing or tell a precise story (Gil, 1991). A good example of a nondirective approach may be viewed in Virginia

Axline's book *Dibs in Search of Self* (1964). In this book, Axline generally allowed Dibs to choose his activities. She encouraged him and allowed him to work through his feelings on his own.

Appropriate Clients for Play Therapy

Depending on the developmental stage and complex reasoning skills of the child, most children involved in play therapy are between the ages of 3 and 11 (Kottman, 2003b). Researchers have found that many children may be appropriate for play therapy, especially those who have experienced trauma (Gil, 1991). Children who have experienced trauma may be involved in the play therapy process as young as the age of two, or as old as age 15 (Gil, 1991).

Further research based upon subjective case studies and empirical research has found the use of play therapy effective with children with a diagnosis of adjustment disorder, posttraumatic stress disorder, dissociative disorder, depressive episodes, or specific fears and phobias (Kottman, 2001). Moreover, there is evidence that play therapy may be appropriate for children with aggressive, acting-out behavior, abuse and neglect, family violence, grief issues, divorce of parents, and severe trauma (Kottman, 2001).

Play therapy may not be appropriate for children with severe conduct disorder, severe attachment disorder, or children who display symptoms of psychosis (Kottman, 2003b). These children may require more medical or behavioral approaches (Anderson & Richards, 1995, as cited in Kottman, 2001).

Children with ADHD, Major Depressive disorder, Separation Anxiety disorder, mental retardation, or learning disabilities may be appropriate for play therapy if it is used in combination with medication (Kottman, 2003b). It is important for the play therapist to be clear with the parents about precise goals, explaining the limitations of what a play therapist can and cannot do (Kottman, 2001).

The Play Therapy Room

According to Landreth (1991), there are several things that should be present in the "ideal" playroom. Landreth (1991) recommended that the playroom should measure approximately 12 feet by 15 feet, with an area between 150 and 200 square feet. It is also essential that the room have privacy so children feel safe divulging information (Landreth, 1991). The playroom should be sound-proofed if possible, to provide the child with confidentiality (Axline, 1974). All surfaces should be washable, as children may make messes while in therapy. The room should include a sink with cold water and a chalkboard, and the furniture should be appropriate for children (Landreth, 1991). Finally, a one-way mirror and equipment for listening to sessions may improve the opportunity for supervision and self-monitoring (Landreth, 1991).

The playroom should be a place of comfort; children should feel happy, safe, and welcome (Kottman, 2001). Even though most approaches to play therapy have a variety of classifications of appropriate toys, Landreth (1991) suggested that toys and play materials should assist a wide range of emotions and

creative expression, engage a child's interest, encourage verbal and nonverbal expression by children, and be sturdy and safe for children to use in the playroom.

Play therapists should try to ensure that the placement of toys is predictable and consistent; toys should go back to nearly the same place after every session since this provides a child with safety and structure (Kottman, 2003b). In the playroom, toys are often divided into well-defined categories. These categories may include family/nurturing toys, scary toys, aggressive toys, expressive toys, and pretend/fantasy toys (Kottman, 2001). Each category is unique, but may be interchangeable. For example, toys may be appropriate for use in more than one category. Children often meet various therapy needs by using similar toys (Kottman, 2003b).

Child Abuse

According to Kharti (2004), child abuse may be defined as causing or allowing harmful contact on a child's body. Child abuse is a source of trauma for many children and is a very serious issue worldwide (Monahon, 1993). Throughout history, children have been subjected to differing forms of abuse and mistreatment (Summit, 1988). Gil (1991) believed that abuse may often occur as children are viewed as the property of their parents.

A pertinent example of this occurs in the book *A Child Called It* (Pelzer, 1995). In this book, Pelzer explained the massive amount of abuse he received from his mother. Among other things, he was starved, beaten, and forced to sleep

in the garage on a cot. For years his teachers and other members of the community did not say anything, as it was believed that children are the property of their parents, and what goes on at home, stays there.

In recent years, experts have considered the child abuse and neglect problem a pandemic (Children Today, 1992). Approximately 906,000 children were concluded to be victims of child abuse in the United States in 2003 (Hopper, 2005). Child fatalities are the most heartbreaking consequence of abuse, and in 2003, an estimated 1,500 children died (Hopper, 2005).

The level of child abuse in America has reached shocking proportions, with approximately one child being abused or neglected every 13 seconds (Briscoe, 1994). According to The National Child Abuse and Neglect Data System (2004), an estimated 1,400 children died in 2002 due to a child abuse or neglect injury. Thus is equal to 1.98 children per 100,000 in the general population (The National Child Abuse and Neglect Data System, 2004).

Types of Child Abuse

According to Kharti (2004), there are four major types of child abuse: physical abuse, emotional abuse, sexual abuse, and neglect. Physical abuse occurs when an injury is imposed upon a child and may include burning, hitting, punching, shaking, or beating (Kharti, 2004).

Emotional abuse includes acts or the failure to act by caretakers that may cause serious behavioral, cognitive, emotional, or mental disorders. Acts of

emotional abuse may include peculiar forms of punishment or confinement, belittling, habitual blaming, or rejecting a child (Kharti, 2004). Sexual abuse may be defined as inappropriate sexual acts with a child. These acts may include fondling of genitals, rape, incest, or intercourse (Kharti, 2004). Sexual abuse that is associated with by threats, betrayal of trust, violence, or physical injury causes the most severe psychological attacks on children (Monahon, 1993). In order for child abuse to occur, it needs to be committed by a person responsible for the child's care, or by a relative of the child. If the acts occur by a stranger, that is considered sexual assault (Kharti, 2004).

Finally, neglect is the failure to provide for the basic needs of a child (Kharti, 2004). Neglect is often divided in the categories of physical, educational, or emotional. Physical neglect may include not providing appropriate medical care, food, water, or clothing (Kharti, 2004). Educational neglect includes the failure to provide a child with proper education (Kharti, 2004). Emotional neglect includes the lack of support, love, or attention (Kharti, 2004).

Consequences of Child Abuse

Child abuse is associated with several negative consequences and the impact of abuse on children is usually very detrimental (Gil, 1991). Children are often unable to completely understand or explain the impact of abuse (Gil, 1991). Therefore, professionals usually rely on the development of symptomatic behaviors to designate emotional difficulties in children (Gil, 1991). Research

has indicated that common problems displayed by child victims include depression, anxiety, physical effects, injury, pregnancy, cognitive problems, learned helplessness, aggressive and antisocial behaviors, poor self-esteem, and withdrawal (Gil, 1991; Bratton & Ray, 2000).

Apart from the above mentioned problems, child abuse may also have other consequences. For example, a child may alienate or become reclusive (Kharti, 2004). Child abuse may encourage children to lie, resent, fear, and retaliate (Kharti, 2004). Additionally, child abuse may lower a child's self-esteem and affect his or her psychological development. Finally, victims of child abuse may carry on the abuse with their own children (Kharti, 2004). It is not uncommon to have second and third generation abusers (Briscoe, 1994).

Briscoe (1994) conducted a study of 1,575 children. In this study, 908 children were victims of child abuse, and 667 children were not victims of abuse. The results indicated that the abused children were 53 percent more likely to be arrested as juveniles, 38 percent more likely to be arrested as adults, and 38 percent more likely to be arrested for committing a violent crime (Briscoe, 1994). These abused children were also more likely to have mental health problems, educational problems, health and safety issues, and occupational difficulties (Briscoe, 1994). It is therefore apparent that child abuse has several negative consequences.

Play Therapy with Abused Children

There have been some supporting studies noting the effectiveness of play therapy with victims of child abuse. More research is definitely needed on this important topic, as a significant amount of children referred for psychiatric treatment have been sexually abused (Roesler, Savin, & Grosz, 1993).

Play therapy has been understood as a process of working past difficulties and painful experiences and as a guide to rebuilding the child's past (Ablon, 1996). Play therapy provides children with the perfect environment where they feel safe and they may experience their feelings without limitations (Landreth, 2002). In the playroom, children are in control of their actions and they gain confidence about their ability to complete tasks (Miller, 1999). A review of the child's play may be helpful in understanding the child's experience (Gil, 1991). There can be tremendous strength in having a safe space to ease emotional trauma in the presence of an accepting adult therapist (Monahon, 1993). Oftentimes, play allows children to distance themselves from experiences that are quite painful if expressed directly to a therapist (Monahon, 1993).

According to Gil (1991), when assessing the treatment needs of abused children, it is vital to consider a number of issues including the phenomenological impact of the abuse, the family's level of dysfunction, the environmental stability, the age of the child, and the child's relationship to the offender. Gil (1991) also

emphasized the importance of focusing on the therapeutic relationship between the therapist and the child.

Among other things, Gil (1991) emphasized the therapeutic relationship, explaining rules and structure, setting limits, providing opportunities for self-exploration, adaptation and new behaviors, and understanding a child's feelings. Gil (1991) further believed that therapists should actively examine and engage in a child's play.

Like any other therapy, there are several treatment goals associated with play therapy with abused children. Gil (1991) believed that a main goal was to provide healing experiences for the child that can encourage the child to develop a sense of trust, safety, and well-being. According to Griffith (1997) treatment goals should include establishing a relationship that will allow children to work through their difficulties, providing opportunities for self-exploration, working to understand the child's experiences, attempting to convey that understanding back to the child, and being aware of the child's present developmental stage.

There are several important techniques that need to be present when working with abused children. According to Azar & Wolfe, (1989) "The clinician who chooses to work with abused and traumatized children is advised to establish a method for assessing the need for trauma resolution work, providing context and direction, facilitating posttraumatic play, and making timely interventions" (p. 481).

Although there has not been a lot of empirical research on the effectiveness of play therapy with abused children, this paper has outlined some important facts as to why play therapy has often been labeled as effective. As much of the research explains, it is important to trust the process and monitor the child throughout the duration of therapy (Axline, 1974; Gil, 1991; Landreth, 1991, 2002; Kottman, 2001, 2003b). By establishing a strong healing relationship, and providing a safe environment for a child to play, self-esteem and independence will often increase (Landreth, 2002).

Implications and Recommendations for the Profession

According to Gil (1991), play therapy with abused children is an area that is constantly evolving; as more research is conducted, more information will become available regarding effective techniques.

When working with abused children, it is important to remember that children generally react to psychological trauma quite rapidly (Monahon, 1993). Signs of trauma may include an extensive range of noticeable behaviors that are often good indicators of a child's distress, including excessive fear and anxiety, sudden panic or distress, separation anxiety, physiological reactivity, behavioral regression, loss of pleasure in enjoyable activities, retelling or replaying of the traumatic event, personality changes, and sleep-related difficulties (Monahon, 1993).

In addition, the precise nature of the trauma has some influence over the intensity of the children's reaction (Monahon, 1993). These aspects comprise the duration of a traumatic events, the presence of interpersonal violence or harm, the child's perception of the outcome of the trauma, the extent of disruption the child experiences in basic care-taking, and the family's functioning as a result of the trauma (Monahon, 1993).

Children's response to trauma may be perplexing, even to professionals (Monahon, 1993). There are several factors that may contribute to the specific reactions of a given child. For example, it is important to keep in mind the child's temperament and coping style, the child's self-confidence and intelligence, the child's age at the time of the traumatic event, the child's gender, the child's prior development and experience with stress, the family's ability to respond with support and protection, and the family's access to community support (Monahon, 1993). Although families may be hesitant to obtain needed support or assistance, the sooner the traumatized child gets professional help, the better the chances are that the child will profit from it (Monahon, 1993).

As Kottman (2001) has pointed out, subjective case studies and empirical research have emphasized that play therapy is an appropriate therapy for many different diagnoses such as adjustment disorder, posttraumatic stress disorder, dissociative disorder, depressive episodes, and fears and specific phobias. Furthermore, play therapy is an effective intervention for children struggling with

anxiety and withdrawn behavior, abuse and neglect, divorce of parents, family violence, grief issues, issues related to adoption, and severe trauma (Kottman, 2001).

Conclusion

Play therapy is defied as the "Systematic use of a theoretical model to establish an interpersonal process in which 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 1997, p. 4). Play allows children to deal with feelings that are important, enabling them to better manage their emotions (Ablon, 1996).

Although not too many empirical studies have been conducted, play therapy has been a topic of significant interest over the past several decades (Gil, 1991; Kottman, 2001; Kottman, 2003b). Researchers have found that many children may be appropriate candidates for play therapy, especially those who have experienced trauma or abuse (Kottman, 2003b).

Child abuse is a very serious problem in the United States and around the world (Kharti, 2004). Previous research indicates that child abuse is associated with a number of severe problems including depression, anxiety, physical effects, injury, pregnancy, cognitive problems, learned helplessness, aggressive and antisocial behaviors, poor self-esteem, and withdrawal (Gil, 1991).

Play therapy provides children with the appropriate environment where they feel safe and they may experience their feelings without limitations (Landreth, 2002). Oftentimes, play allows children to distance themselves from memories and experiences that are rather painful if discussed directly with a therapist (Monahon, 1993). By creating a strong therapeutic relationship and providing an appropriate setting, play therapists encourage independence and increased self-esteem in the lives of abused children (Landreth, 2002).

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