Rebuilding little lives: using play therapy with traumatized children

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Abstract
In this paper, the author will attempt to assist therapists with their work with traumatized children using play therapy. The discussion includes signs and symptoms that a traumatized child may exhibit. In addition, the paper will contain selected therapeutic powers of play and how they can aid in the treatment of traumatized children. The case examples provided throughout this paper are actual experiences taken from the author's clinical practice in a hospice setting.
REBUILDING LITTLE LIVES: USING PLAY THERAPY WITH TRAUMATIZED CHILDREN

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Play is a child's natural way of communicating and expressing the self. Play allows children to explore and express feelings that they may be unable to express verbally due to underdeveloped skills (Wolfelt, 1996). Given the opportunity, children will play out their feelings and needs similar to the way an adult would communicate it verbally (Landreth, 1982). Toys and play are the words for children that provide an avenue to act out feelings and difficulties they may be experiencing (Landreth, 1982).

Traumatized children are usually emotionally defended, but deep inside them are powerful and terrifying beliefs that they are helpless, bad or at fault (James, 1989). A child's defense mechanisms may be so exhausted by attempts to cope with trauma that the child may have difficulty in learning new things or simply coping with the ordinary demands of life. By intervening in the child's response to trauma, potential pathology may be averted (Everstine & Everstine, 1993).

Play therapy with traumatized children provides an outlet through the medium of play in the context of a therapeutic relationship (Webb, 1991). Through the interpersonal interactions with the therapist, the child may experience catharsis, reduction of troublesome affects, redirection of impulses, and a corrective emotional experience (Webb, 1991). In the playroom, a child can express his or her feelings in fantasy--eventually working through and mastery, which can carry over to the child's everyday life (Webb, 1991).
In this paper, the author will attempt to assist therapists with their work with traumatized children using play therapy. The discussion includes signs and symptoms that a traumatized child may exhibit. In addition, the paper will contain selected therapeutic powers of play and how they can aid in the treatment of traumatized children. The case examples provided throughout this paper are actual experiences taken from the author's clinical practice in a hospice setting.

Characteristics of Psychic Trauma in Children

Psychic trauma is a term used to describe the effect on a person of an extremely stressful life event (Schaffer, 1994). The process of trauma results from the perception of an overwhelming event with feelings of helplessness, powerlessness and hopelessness (Barnes, 1996). Terr (1991) categorized psychic traumas as either Type I (single, sudden, and unexpected stressor) or Type II (longstanding and repeated ordeals). Terr noted that Type I traumas do not appear to exhibit the massive denial, psychic numbing, dissociation, depersonalization, rage or personality disorders that characterize Type II traumas. This paper focuses on Type I traumas in children.

Based on extensive work with child victims of trauma, Terr (1991) observed several common childhood reactions to trauma. She described four characteristics that children appear to exhibit after an unanticipated, single, traumatizing event: (a) full, detailed, etched-in memories; (b) "omens" (retrospective reworkings,
cognitive reappraisals, reasons and turning points); (c) misperceptions; and (d) post-traumatic play and reenactment.

**Full, Detailed, Etched-in Memories**

Traumatic memory functions differently from ordinary kinds of childhood memory. Traumatic memory is broken down into the same three functions of memory--input, storage, and retrieval. However, traumatic remembrance is far clearer, more detailed, and more long-lasting than ordinary memory (Terr, 1990).

An untraumatized child who experiences or witnesses one terrible event has the ability to retrieve detailed and full memories afterward. Verbal recollections of single shocks are expressed in a clear and detailed fashion. At times, children are able to remember more about the event than the adults who witnessed or experienced the same event. No matter how much the child tries to consciously suppress them, the memories stay alive. Children who have been traumatized a single time often do not forget the traumatic event (Terr, 1991).

However, a few details from the traumatic event may be factually wrong due to initially misperceived or mistimings of the sequence of what happened (Terr, 1991). Most false traumatic memories have nothing at all to do with lying or with the suggestions from others. Instead, they come directly from what was heard and felt during a traumatic experience. Children have the ability to transfer perceptual impressions from one modality (feeling or hearing) to another (seeing). They simply experience a transfer of perceptual impressions. Children, then, suffer
from bothersome, visual memories of what had never, originally, been seen (Terr, 1990).

For example, Mark, 13 years old, recalls when his dad died from cancer. His father "bled out" when he died. Mark's mother and sister were present when he died so they saw this happen. They decided not to wake Mark. However, Mark was awake and could hear his father gasping and vomiting blood, but he did not see his father. Mark came out of his room after his father had died. There was a huge puddle of blood on the carpet. Mark's image of how his father died was actually much worse than reality. Given what Mark had heard, he created his own visualization of the occurrence.

**Omens**

Omens are an impressive indication of how the child tries to solve the traumatic event in retrospect, even though in reality such an exercise is useless (Terr, 1983). During and after single-blow shocks, children try to rationalize why the event happened, what the purpose was, or a way the disaster could have been averted. Children may ask themselves "Why me?". Considerable energy goes into these reworkings of the past. This reasoning is a belated way to deal with an event which was entirely unexpected (Terr, 1991).

Sometimes, the child assumes personal responsibility and even guilt for the event (Terr, 1983). Children attempt to resolve their vulnerability and lack of control by saying they could have avoided the event if only they would have
listened to different responses that they believe were telling them the traumatic event was going to happen (Gilliland & James, 1988).

For example, Kris, 16 years old, was involved in a car accident with her friend. Her friend, Judy, who was driving, was killed. At the time of the crash, Kris had been talking to Judy about a boy she was interested in dating. They were both deeply involved in conversation. Kris believed that it was her fault that Judy was killed because if she had not been talking about this boy, Judy would have been paying more attention to driving.

**Misperceptions**

Cognitive functions are disturbed during a psychic trauma (Terr, 1981). Many of the Type I traumas include visual misperceptions and hallucinations. Visual hallucinations and illusions are observed in children during, shortly after, and, at times, long after a traumatic event (Terr, 1991).

Visual misperceptions and hallucinations appear far more often than other sense-related perceptions (smell, hear, feel, taste). Seeing apparently dominates all other senses following a trauma. It is the sense that records and reviews the event in the mind. These traumatic "tapes" are almost always replayed in silence (Terr, 1990).

Children may hallucinate during a traumatic event. They may experience visions where there had actually been nothing at all to see. These hallucinations may cause a feeling of insanity. However, perfectly normal people experience
visions under certain circumstances (high fevers, sleep deprivation). Pure fright, a nonorganic, nonpsychotic condition, could create visual misperceptions and hallucinations (Terr, 1990).

Misperceptions do not stop with a traumatic event itself. They could appear in a child's memory after he or she had thought things through, heard rumors, or even after he or she had rerun mental "tapes" a few hundred times. These misperceptions can be brought on when the child visits a place where the event occurred; when someone else mentions the event; when something connected with the trauma comes to mind through association; and when the smells, the atmosphere, and the season renew a sense of "being there" (Terr, 1990).

For example, Travis, 7 years old, witnessed his babysitter get shot when she answered the door. The shot happened in the doorway with no gunfire going off in the house. After the trauma, Travis believed that a bullet went right past his sister's head as she was sitting on the couch. Travis has misperceptions about the event that could possibly be due to hallucinations during the event or they could be misperceptions that appeared in his memory after going through the event in his mind several times.

Post-Traumatic Play and Reenactment

Play and behavioral reenactments are frequent manifestations of single blow traumas (Terr, 1991). Post-traumatic play is a distinctive type of play involving a rigid repetition of the traumatic scene. Post-traumatic play involves a joyless
scenario, lacking in expressive freedom. The normal world of childhood play is free, spontaneous and enchanting. There is an exuberance and release rather than the obsessive quality that is found in post-traumatic play (Barnes, 1996).

Intervention is crucial when it comes to post-traumatic play. Otherwise, feelings of helplessness and hopelessness are reinforced. In this type of play, the child repeatedly acts out the trauma rather than processing it in a manner that leads to any kind of resolution (Barnes, 1996).

Reenactment of a trauma in play can either lead to mastery or a retraumatizing experience (Schaefer, 1994). The problem comes with fixed post-traumatic play when there is identical negative outcome, no change, no resolution, and only a constant repetition of the traumatic event (Barnes, 1996). Reenactment of a trauma can become mastery rather than retraumatizing play when a child does the following (Schaefer, 1994):

1. Feels in control of the outcome of the play.
2. Plays out a satisfactory ending to the play.
3. Feels free to express and release negative affect.
4. Exhibits a cognitive reappraisal of the event.

In addition, it is vital to process the feelings and dynamics of the experience. Therapists must build in a sense of safety and protection. This needs to involve both allowing children to play things out and talk about what happened to them (Barnes, 1996).
As noted above, Travis, 7 years old, witnessed his babysitter get shot. The babysitter lived, yet Travis was very frightened and felt unsafe. In sessions, he would repetitively use the dart gun to shoot a puppet in the back and then play doctor and remove the bullet. When the therapist would ask Travis "how could the puppet be safe," Travis said that no one was safe and that there was no place for anyone to hide that was safe because the person with the gun can find anyone, anywhere. Travis was unable to come up with a resolution for the puppet to feel safe. With the therapist's guidance, Travis figured out ways in which the puppet could be safe from the shooter.

**Therapeutic Powers of Play**

Play therapists can use certain therapeutic factors when working with traumatized children to provide structure and a foundation to the therapeutic process. Schaefer (1993) described 14 therapeutic factors of play. They include:

(a) overcoming resistance, (b) communication, (c) competence, (d) creative thinking, (e) catharsis, (f) abreaction, (g) roleplay, (h) fantasy/visualization, (i) metaphoric teaching, (j) attachment formation, (k) relationship enhancement, (l) positive emotion, (m) mastering developmental fears, and (n) game play.

Based on the author's experience with children who have experienced a trauma, the therapeutic factors that would be most helpful with traumatized children are overcoming resistance, communication, catharsis, abreaction, metaphoric teachings, and positive emotion. These factors appear to be related to
children who may be having difficulties from a traumatic event, as opposed to a children that are having problems associated from other issues such as social problems and adjustment difficulties.

For the remainder of this paper, the example of Bobby will be used for each of the therapeutic factors of play. Bobby (8 years old) was involved in a car accident that killed his mother and left his father paralyzed with a head injury. His older sister was also in the car, but survived with minor injuries. He was the only one conscious throughout the ordeal. He received only minor cuts and bruises. The event left Bobby feeling guilty because they were in the car going to the shopping mall to get Bobby a pair of Nike high-tops that he insisted on having before school on Monday.

His guardians had Bobby start counseling because they noticed some "acting out" behaviors. When Bobby played with his trucks and cars, he continually smashed them into one another and then had the ambulance come and pick up all the people. When he played with his friends, he was very aggressive with them. The teachers would say that he did not pay attention in class and he seemed to "space out" during class. He had discussed the accident with his guardians and became frustrated when he could not recall the ride in the ambulance and being in the hospital room. However, he was able to recall the accident itself, including sounds he heard and the fears he had.
Overcoming Resistance

Many children will experience resistance when entering a therapeutic process. It is scary for them to not know what to expect. They may not understand the process or why they have to see a therapist. The responsibility of the therapist when working with a traumatized child is to create a safe, comfortable environment (Schaefer, 1993).

Overcoming resistance may be one of the first tasks that a therapist works towards when working with a traumatized child. Children may come to therapy only because they believe they do not have a choice. Once in a therapist's office, they may admit to having a problem but are frequently unable to provide discussion around it. An inexperienced therapist may want to gather a lot of information during the first few sessions. However, a child may reply with a shrug or blank stare. Allowing a child the freedom to explore the play room and to become comfortable with the therapist is important for the development of the relationship and eventually will help to eliminate initial resistance (Schaefer, 1993).

For a therapist working with Bobby, the first task would probably be to become comfortable with one another. Not only would the therapist have to get to know Bobby, but Bobby would have to become comfortable with the therapist. This would involve the therapist creating an equal relationship, one in which each person honors and respects the other.
By using play, verbalization may be facilitated. Landreth (1982, p. 38) stated that "play can be used to help a child verbalize certain conscious material and the associated feelings." It can create the distance necessary so that the Bobby can feel comfortable to talk about the traumatic event. Due to the nonthreatening nature of the play therapy process, this can assist in defusing any resistance.

**Communication**

Play is a safe way for traumatized children to communicate. It can be a way for a traumatized child to express themselves safely through the natural facilitative dimensions of play (Schaefer, 1993). For example, a traumatized child who is having the symptom of "omens," play therapy can help the child gain some sense of control of the event. Play can be children's way of working out feelings of anxiety and fear and reestablishing some sense of balance and control in their lives.

Bobby had a belief that the car that hit him and his family was purposely out on the roads killing people. The author believes this was suggested by his drawing of the car with a knife as the bumper. Bobby would not communicate this verbally to the therapist. However, by communicating this through drawings and clay molds, the therapist was able to identify why Bobby had a fear of cars and would not go on long trips.
Catharsis

The basic premise of catharsis is that the failure to release emotions tied to the traumatic event may eventually lead to maladaptive attitudes and behaviors (Schaefer, 1993). Releasing the emotions related to the traumatic event may free the person of those emotions. As a result, the person may experience improved well-being and have more adaptive functioning. The implication of this is that, through the release of emotion and cathartic expression, feelings which have not been expressed are reduced and change occurs (Schaefer, 1993).

Traumatized children may express many of their emotions in a way that is viewed as inappropriate by adults. Unfortunately, children frequently do not have the coping mechanisms that adults have. In addition to not knowing how to appropriately express their feelings, they may experience an adult who does not understand what they have experienced. For example, the child may be aggressive at school and not able to sit still. This child may be given a diagnostic label when actually the child is expressing his or her feelings surrounding a disturbing experience. In an atmosphere of play, catharsis and emotional release are important components of therapeutic change. For catharsis and emotional release to occur, there needs to be a permissive environment, acknowledgment and acceptance from the therapist and a few limits that set some sort of structure for the child. Under these conditions, children are more likely to be able to release emotions and thoughts and express them in a constructive manner.
Bobby felt a rage towards the man who hit their car. His teachers were frustrated with Bobby because he was very aggressive to the other children. In therapy, he used the Bobo doll to represent the man. Using the Bobo doll as the focus of his hostility, he hit, kicked, screamed, shot with the dart gun, and stabbed with the plastic knife. This released the intense rage Bobby felt towards the man. All of this activity was met by the therapist in an understanding, accepting manner. This release freed Bobby of the intense anger he felt and allowed him to express it in an appropriate, therapeutic manner.

Abreaction

Abreaction is the reliving of past stressful events and the emotions associated with them (Schaefer, 1993). It is a more heightened process than catharsis in that the discharges of affect is greater. In play, children can take their time at digesting and assimilating traumatic experiences by reliving them with an appropriate release of affect. Traumatized children play out similar situations and gradually achieve mastery over them. In play, the child has control of the event and there is less anxiety because it is just "pretend" (Schaefer, 1993).

Some children may be able to verbalize the traumatic event, while others will do better using less verbal methods of describing the event. The following methods can help children retell their story:
• Using toys to represent themselves, such as a doll house with family figures, small animals, cars and trucks. These can be used to reenact the event.

• Puppets are helpful to express the child's feelings.

• Free drawings can reference the traumatic event.

• The use of clay and moldings can provide a means for a child to express their feelings. If the child appears to be angry, the use of a mallet is helpful to smash the clay.

As noted earlier, Bobby had a fear of cars and traveling. The therapist would have Bobby use puppets riding in a car. The therapist would ask Bobby which puppet was him. Then the therapist would have him reenact a car trip and identify what Bobby would have control over in the car and what he would not. This allowed Bobby to recognize power that he had in the situation and accept which events were out of his control.

Metaphoric Teaching

The goal of therapeutic metaphors is to offer new choices, show different ways of perceiving a situation, and tap a variety of dormant beliefs, attitudes and values of the child (Schaefer, 1993). Using metaphors, through storytelling, art techniques, analogies, proverbs, cartoons, music or using puppets, can be useful when working with traumatized children. The play, itself, that a child engages in
is a metaphor. The therapist can bypass protective barriers and slip important messages to the child. Metaphors can present an idea in a more gentle manner.

A parable is the way the therapist introduced to Bobby a discussion on saying goodbye to his father. Bobby had expressed that he was afraid his father was alone in heaven and that if he "let go" of him then he would not have anyone. The following is the parable the therapist used:

I am standing upon the seashore. A ship at my side spreads her white sails to the morning breeze and starts for the blue ocean. She is an object of beauty and strength. I stand and watch her, until, at length, she hangs like a speck of white cloud just where the sea and sky come to mingle with each other. Then someone at my side says: "There, she is gone!" "Gone where?" Gone from my sight. That is all. She is just as large in mast and hull and spar as she was when she left my side, and she is just as able to bear her load of living freight to her destined port. Her diminished size is in me, not in her. And just at the moment when someone at my side says: "There, she is gone!" There are other eyes watching her coming, and other voices ready to take up the glad shout: "Here she comes!"

(Anonymous)

Positive Emotion

Play is an activity that is fun. The positive affect accompanying play has two therapeutic advantages. First, it adds to a sense of happiness or well-being. Second, humor and enjoyment can counteract the stressed of life. Play is free
from demands, obligations and serious intent. When children engage in play, the positive emotion that appears to be experienced is happiness. By being happy, the child can relax and disregard worries of expectations. This relaxation can cause the child to be open and responsive to the therapist (Schaefer, 1993).

The author believes that a child who has experienced a trauma may view life as gloomy and grim. There may be feelings such as sadness, anger, and fear. Children who have experienced a trauma may have difficulty having fun. Children need and will take breaks in their grief. A therapist needs to recognize and be respectful when a child is at this point. Children who have been exposed to a trauma have had to grow up and become adult-like very quickly. By encouraging children to play and have fun, the play therapy process reminds a traumatized child that he or she can laugh and be silly.

Periodically, Bobby and his therapist would play tag together. Bobby would laugh and smile. This created a more relaxing environment and relieved Bobby of feelings of anxiety when he came to therapy. He knew he could come to therapy and still be a kid.

Conclusion

Play is an activity that was a part of the child's life before the traumatic event. After being traumatized, one way of feeling safe and certain may be in the world of play. By incorporating play in the work with children, insights and information
that they may never have gotten if it was presented in the traditional therapeutic mode of questions and answers will be provided.

Adjusting to a traumatic event may be difficult for everyone, especially children. Traumatized children may exhibit certain signs and symptoms. These signs and symptoms may not be understood by the child's parent, teacher, guardian, and other adults. Adults tend to deny or minimize the psychological impact of traumatic events on children and try and shield them from painful recollections.

It is important for the therapist to educate the adults in the child's life. Therapists can provide education to the adults on how children grieve and the differences between adult and child grief. Therapists can encourage adults to be honest about death and loss with children. Lastly, a traumatized child requires patience and understanding. Adults need to be encouraged to provide appropriate reassurance to the child and recognize that the process takes time.
References


