

Directive or Nondirective Play Therapy?

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A small office, plastic bins full of toys, sand tray, desk, computer, two chairs, small table, and a young boy, too scared to talk, transformed this space into a never-ending battle between good and evil without saying a word. The following is a case presentation in which nondirective play therapy was initially used, followed by directive play therapy through the course of a two-year period of time with a nine-year old boy. This therapy took place in a nonprofit community agency setting in a specific sexual reactive program designed for children and adolescents with a history of sexually inappropriate behaviors, sexual abuse, and sexual offending issues.

During the initial session, the client was still in his mother's custody. His mother refused to allow the client to come to the office without her. She asserted that she be present in sessions because of the client's previous disclosures of sexual abuse in the home. This client was subsequently removed from the

home of his family of origin and put into therapeutic foster care.

The client was administered the K-SADS, which is a semi-structured, diagnostic interview used to determine various disorders and symptoms. (Kaufman et al, 1996). This client met criteria for Bipolar I disorder with psychotic symptoms, enuresis, posttraumatic stress disorder and a rule out diagnosis of conduct disorder. This client was then administered a complete sexual history questionnaire, which is a semi-structured clinical interview used to ascertain various information about the client's sexual history and sexual knowledge (Taylor, 1999). The assessment process was difficult for the client, and most sexual information was told by the child via play therapy techniques. Techniques used in the assessment process included the paper doll activity, (Crisci Lay & Lowenstein, 1998), the play genogram (Gil, 2006), Kinetic House Tree Person (Burns, 1987), Draw a Person in the Rain



(Taylor, 1999), and the use of anatomically correct dolls (Gitlin et al, 2000). During this assessment process, the client admitted to sexually touching his older sister and brother. I had no idea that the client and I were about to embark on a journey that would change the way that I practice and interact with clients.

The client was placed in a stable foster care home. He presently has no contact with his mother or siblings. His other siblings are also in foster homes with supervised visitation with their mother but no contact with each other. This play therapist has been working with this client for the past two years. Initially, sessions were weekly. The client's play was nondirective, guarded and non-interactive with therapist. He mostly sat with his back to the therapist and played quietly and intently, with purpose. He would place his battle characters in the sand, then the floor, then the window sill, then the desk, to the chairs, and finally on the computer! All the while not even looking at me or acknowledging my presence, strategically and methodically placing the army and rescue vehicles all over the office. It was not until after the sessions that I realized I had witnessed posttraumatic play. This play would always end with the "good" army men "dying" and not being able to be "saved." Reflective listening was attempted but the client would often tell the therapist to not look or talk to him. Was I helping him?

This style of play lasted about eight months. During this period, the client used puppets, a dollhouse and miniatures, sand, play dough, artwork, paint, crayons, and books as avenues of play. The only other modality, which the client would engage, though rare, at this time, was the artwork. The Kinetic House Tree Person technique (Burns, 1987) was also used. The KHTP is a projective technique used to assist practitioners with "understanding the emotions and feelings about self" (Burns, 1987) of a client in a visual metaphor. These techniques showed depersonalization, evidenced by heads and bodies being separated, sometimes on different pages. Encapsulation was also evident in every drawing, as well as "X" on every torso. These could be construed as evidence of sexual abuse, neglect, or physical abuse. He had a very low frustration tolerance, as evidenced by ripping up his drawings if he could not get it "just so." When asked about school, he would "shut down" emotionally. He would begin verbally acting out in the therapy room after a hard day at school. He would scream at this therapist that he "hates" her and is "never coming back." He would then curl up on the beanbag and put his coat over his head and cry, then fall asleep. This happened during a few of the sessions nearing the eight-month mark of treatment. He is either sleeping or yelling at me in sessions; how could this be helping him? This type of acting out in therapy indicates that the client was feeling safe in the play therapy room, and transferring to the therapist his feelings about his situation; primarily, his abusive mother. He was so traumatized and his presentation was so regressed that he presented as if he was on the pervasive developmental disorder spectrum. His motor skills were delayed (his pictures often looked like that of a three-year old), his speech and language was delayed, his eye contact was poor, social skills were poor (fighting and cussing at peers.)

Through this initial eight-month period, this client regressed at home. The client experienced daily nocturnal enuresis, difficulty at school (fighting, cussing, sexually inappropriate

comments to peers and teachers.) He did not have any misbehavior in the foster home. He did however continue to experience auditory hallucinations. He appropriately attached to the foster mother and father, and would cry when he would notice his use of the words "mom and dad." This seemed to be part of the grief process. Though many other interactive play therapy techniques were attempted (e.g. board games, interactive storytelling, interactive puppet play, etc.), he just could not tolerate any directive techniques. He would disengage at the suggestion of another modality of play, climbing under the furniture, refusing to participate. Therefore, it was imperative to continue to collaborate with the foster parents and the county child services worker to coach them with regard to the client's sexualized behaviors, and "meeting the client, therapeutically, where he is." He would "hump" his bed at home, talk about wanting to perform oral sex on his peers at school, and would use profanity when he did not get his way. To any outside person, this client looked like a "bad kid." To me, he was hurt and struggling to just survive. He was on a strict 24-hour supervision safety plan, because of his high risk of sexualized behaviors with peers. It was difficult to see progress, as this client was mostly nonverbal within the therapeutic environment and presented so poorly in community settings. At this time, the client was enrolled in a local partial hospitalization program. Behavioral modification was used, as well as cognitive behavioral techniques (which were not very successful during this period of his treatment). This partial programming proved to be too stimulating for his highly traumatized brain. He had too many rules. These techniques proved ineffective until which time the client began disclosing, through play therapy, his sexual abuse.

Eventually, about one year into the process, the client invited the therapist to engage in the play with him, though he would not tolerate any alternative ending other than the "dying." He maintained control, directing me to "die". He also could not tolerate any alternative ending, like "killing" off my character if attempts were made. Aghh! The working stage of treatment can be seen! The client began to spontaneously disclose more allegations against his mother and stepfather (some of this disclosure began during the artwork listed above, as well as through asking to see the "special dolls.") It is significant to note that, at about the same time as this disclosure was made, the client ceased all inappropriate sexual comments and behaviors, and began to work his Partial Hospitalization program successfully. He also drew pictures of the abuse, as well as did the paper dolls exercise again. His drawings became more integrated whole bodies, though still some detachment from the head and the body, with continued "floating" on the page, as well as encapsulation. Sand tray was used first as a directive approach in which the therapist engaged the client in storytelling. The client created a "world of hurts" in the sand. His world included his family members, a judge, a couple of houses, fences around the mother. He then created a story about his world. It is significant that the client changed his worlds to the reality, which was the client's unconscious way of communicating to the therapist his readiness into acceptance of the therapeutic process. The client was able to identify his

perpetrators in the sand and included "acting out" what happened between the characters in the sand.

At the one-year mark of treatment, this client caught up developmentally with his peers. He can read (thanks to his wonderful and caring foster parents), he continues to thrive in his placement (which is the initial foster placement), and is verbally appropriate with peers and adults. When progress was being made, around the 18-month mark, the client was seen every other week. The "good" would sometimes win if the client had a good day, shifting the client's attention to more interactive play, including hide and seek in the sand with the therapist. This was the first time in 18 months that the client would intentionally touch the sand! Imagine, a 10-year old boy, sucking his thumb (full of sand), talking about his day at school.

At the two year mark, this client continues to thrive in the same placement, has moved down to every other week sessions (with the same therapist), and is now in a mainstream classroom. He is now able to verbalize his feelings appropriately and beginning to appropriately grieve the loss of his biological family from his life.

Various traumatic events in this client's life led this therapist to use the initial nondirective approach. He needed to control the sessions. The process was about his need for safety and security, his need to grieve and thrive. This client was neglected, physically and sexually abused, sexually exploited, and was in an out of home placement. He had no control over his world, except when he came into the playroom. Here, he could be whoever he needed to be, and to "play," how he needed to

play. He had answered many questions by a judge, attorneys, other therapists, his family, and county workers. In the playroom, he was able to work through trauma that no child should ever have to face. He needed a safe place to "play." He needed a "container" to hold his emotion and his pain. He has taught me to stay in the moment with each and every client and that the therapeutic relationship and safety of the therapeutic environment is vital to the growth of the client.

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