# ANALYSIS OF PSYCHODYNAMIC INTERVENTIONS IN THE TREATMENT OF A CHILD DIAGNOSED WITH POST-TRAUMATIC STRESS DISORDER

A DISSERTATION

SUBMITTED TO THE FACULTY

OF

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BY

SCOTT D. HIROSE

IN PARTIAL FULFILLMENT OF THE

REQUIREMENTS FOR THE DEGREE

OF

DOCTOR OF PSYCHOLOGY

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# ABSTRACT

A search of the psychoanalytic literature for support of evidence-based treatments for children with PTSD favored cognitive-behavioral approaches over supportive and expressive psychodynamically-informed treatments. This study attempted to provide a possible model for the use of a psychodynamically-informed case study. One child was selected to study. The child was previously in treatment with this writer for four years. Over the course of roughly three months, pre-treatment measures were taken. The child's teacher completed the Child Behavior Checklist Teacher Report Form (CBCL-TRF) (Achenbach, 1966) and the Self-Perception Profile for Children (SPCC) (Harter, 1985). The measures were repeated at the conclusion of the study. Three sessions were videotaped roughly one month apart from one another and coded using the Child Play Therapy Instrument: Adaptation for Trauma Research (CPTI-ATR) (Chazan & Cohen, 2003). While the child's self esteem rose as measured by the SPCC in several areas, his levels of acting out behaviors and depression as measured by the CBCL-TRF increased. According to the CPTI-ATR, the child used play activity adaptively and had fewer regressions during his play activity. This is not an outcome study as the treatment is ongoing. It is a process study of how on one level symptoms have not changed significantly as yet. However, on another level, the domain of play, a window has opened on a process of change. Behavioral changes may be dependent upon situational changes. More research is needed to understand the process underlying supportive and expressive psychodynamically-informed treatment of post-traumatic stress disorder in children. Specifically, future studies should follow the course of treatment over a longer period of time.

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“We make up horrors to help us cope with the real ones.” --Stephen King

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# CHAPTER I

## INTRODUCTION

Several systemic influences frame this study. First, insurance companies and Medicaid HMOs authorize and limit the number of therapy sessions that a child or adolescent can receive per year in mental health clinics. Second, overseeing bodies of mental health clinics like the Office of Mental Health (OMH), promote the use of evidence-based treatments as standard practices. These imperatives shape the world of mental health services for families. Therapists in child mental health clinics must work within these constraints in the service of children, adolescents and families. Clinical work must be performed efficiently and effectively both to adhere to insurance limits and to respond to the field's movement toward evidence-based treatments.

I have chosen to conduct a case study of a young child diagnosed with PTSD. He is a child with whom I have worked for three years and with whom I have used psychodynamically-informed play therapy techniques. Having recently trained in trauma-focused cognitive behavioral therapy, I have noted that some exclusion criteria prevent children like my patient to benefit from this evidence-based intervention. He was preverbal when traumatized and he is not consciously aware of the specific traumas that occurred. I have chosen to study one child and to see if the psychodynamically-informed play therapy techniques, when subject to reliable measures, will produce a change in the child's symptomatology, concept of self and play activity.

In this introduction, I will summarize some of the conceptions of PTSD and develop a working model for a psychodynamic intervention. In addition, I will clarify some of the internalizing and externalizing behaviors associated with PTSD in young children and develop an understanding of how trauma affects one's concept of oneself and development. I will also review the literature about psychodynamically-informed play techniques in the treatment of PTSD.

What is Posttraumatic stress disorder (PTSD)?

PTSD is an umbrella diagnosis given to individuals who react to a traumatic event or events by manifesting a constellation of symptoms. This general constellation of symptoms in children includes: (1) re-experiencing the event, (2) avoiding the event and any reminders of it, and (3) becoming increasingly aroused as a result of the event.

*(1) Re-experiencing the event.*

Children re-experience the event through traumatic play activity (Pynoos, Steinberg & Wraith, 1995; Terr, 1991) drawings (Cohen, Berliner & March, 2000; Salmon & Bryant, 2002), recurring nightmares (Lieberman 2004; Pynoos, Steinberg & Wraith, 1995) or re-experiencing the event through any of the five senses (Terr, 1991).

Child creators of traumatic play activity (Lieberman, 2004; Terr, 1981) describe the activity as "fun" but the same activity lacks the element of "fun" to an observer. Frequently, gruesome and grim details of traumatic events are replayed over and over. Traumatic play frequently remains unconscious to the child until it is interpreted and connected with the traumatic event. In addition, traumatic play does not always alleviate anxiety for its creators (Terr, 1981). In this respect, repetitive traumatic play can be classified more as a re-enactment of the original event than typical play activity.

One nine-year-old boy, who after witnessing the Challenger space shuttle explode recalled a "weird" behavioral reenactment in which he baked something with the wrong ingredients. Without consciously realizing, he erroneously put salt in the mixture and turned the oven to high. The entire dish exploded (Terr, et al., 1999).

All children may re-experience the event; however, not all are able to report their experiences verbally. Children under the age of 12 months (Terr, 1988) who have experienced traumatic events before the development of language are also prone to re-experiencing the event. Pre-school children (Salmon & Bryant, 2002) were reported to display fewer re-experiencing symptoms.

Preverbal toddlers experience nightmares after traumatic incidents, yet because of their undeveloped language, they cannot report on the actual nightmare. In verbal children, recurrent nightmares can occur in disguised forms making it difficult to parse out a traumatic nightmare from a regular nightmare.

Re-experiencing the traumatic event through any of the five senses can occur in children most often at idle times like television-watching, during classes or preparing for sleep (Yule, 2001a). In young children, traumatic reminders are frequently confined to a single image, sound, or smell that the child associates with the immediate threat of injury or traumatic event. Idle, free, unstructured time leaves the child's mind vulnerable to "intrusive" experiences. These intrusions can disrupt a child's focus and concentration. Other vulnerabilities occur when children and adolescents sense physical reminders of the traumatic event, e.g. a smell, a sound that was present at the time of the traumatic event.

*(2) Avoiding the event and any reminders of it.*

Children may avoid the event and any reminders of it through thought suppression, developmental regressions, deliberate avoidances, dissociation (Salmon & Bryant, 2002), and panic/anxiety (Salmon & Bryant, 2002). Blocked or partial memories (Pynoos, Steinberg & Wraith, 1995) are an additional way to avoid the event, minimize the threat of the event, or regulate emotional distress. Disturbances in memories can include omissions and distortions of events, "amnesia" or dissociative reactions (Pynoos, Steinberg & Wraith, 1995). However, avoidance and numbing (Terr, 1991) were less likely to be found in children with PTSD in part because children do not have the developmental capacity for keen self-perception.

Some argument exists in the field concerning the non-verbal memories of children who have experienced traumatic events before they developed language (Yule, 2001a). Ordinarily events are encoded into two memory systems: (1) the declarative or explicit memory system and (2) the implicit emotional memory system (Ledoux, 1998). The explicit memory system encodes the details of the event and contextual facts of the experience and is highly linked to language systems. The implicit memory emotional system encodes the emotional valence of an event and is highly linked to the body's response to danger. During extreme trauma, the memory systems become uncoupled so that bodily/emotional memories become separated from linguistic memories (Van der Kolk & Fissler, 1995). For preverbal children who have experienced traumatic events, their emotional memory systems have encoded events that their declarative or explicit memory systems will never retrieve. Because the memories exist in a form unorganized by language, they continue to influence emotions and behavior (Frayley & Shaver, 1999).

One toddler who witnessed his mother's attacker cut her face during a mugging, was reminded of the trauma by his mother's face. Normally an easy-going toddler, whenever she picked him up to comfort him, he pushed her face away and refused to look at her (Lieberman, 2004). The same toddler experienced developmental regressions and had more difficulty separating from his mother despite his efforts to push his mother away.

Children diagnosed with PTSD can suppress their thoughts and feelings around a traumatic event (Pynoos, Steinberg & Piacentini, 1999). Children report that they avoid specific thoughts, locations or themes that remind them of the traumatic event. Avoidance of favorite activities does not automatically indicate comorbidity of depression. Avoidance can be more related to preventing the expectation of recurrence of the traumatic event (Pynoos, Steinberg & Wraith, 1995). Traumatic avoidance can lead to generalized phobic behavior or restrictions on the scope of a child's activities. Upon witnessing threats to a primary caregiver or to a significant person, children can suppress their fear for their safety and their distress over result of the traumatic event.

The nature of "traumatic" avoidance is specific to the traumatic event. Neurotic phobias in children occur in broad categories like the entire class of dogs. Traumatic avoidance is specific (Terr, 1991), for example to the genus or species of dog that bit a child e.g. Doberman Pinschers or Pitt Bulls.

Avoidance of a traumatic reminder might be a developmental phenomenon. Pre-school children are able to recall aspects of trauma and have conversations about their thoughts and feelings concerning the event (Salmon & Bryant, 2002). Pre-schoolers do not generally avoid discussions of traumatic events. Some researchers speculate that

young children do not report avoidance symptoms because it requires complex cognitive introspection (Dyregrov & Yule, 2006).

*(3) Becoming increasingly aroused as a result of the event.*

Children may experience increased arousal as a result of the event through hypervigilance (Pynoos, Steinberg & Wraith, 1995; Yule, 2001b) and exaggerated startle responses (Pynoos, Steinberg & Wraith, 1995; Yule, 2001b), dysregulated aggression (Pynoos, Steinberg & Wraith, 1995), poor concentration (Yule, 2001a) and mood lability (PDM Task Force, 2006). The DSM-IV lists "irritability and anger outbursts" under this category of increased arousal (American Psychiatric Association, 1994). Several studies (Hoshmand & Austin, 1987; Lehman, 1997; Plutchick & Kellerman, 1974) confirm higher scores of anger on various scales in children and adolescents after a diagnosis of PTSD. Others report more overt aggression, destructiveness and behavioral re-enactments (Dyregrov & Yule, 2006). Anger is present in children and adolescents with PTSD regardless of developmental level. Furthermore, a study (Saigh, Yasik, Oberfield & Halamandaris, 2007) indicates that children and adolescents with PTSD express their anger without any specific provocation.

Increased arousal also affects sleep. Children and adolescents might have night terrors, insomnia (Yule, 2001b), and repeated night wakings (Lieberman, 2004; Yule, 2001a). Attention or hypervigilance can be focused on trauma-related fears and interfere with sleep, (Yule, Bolton & Udwin, 1992). During sleep, an already-vulnerable time of the day, children might be more alert to danger in their environment, whether real or perceived (Yule, 2001a). Sleep disturbances can interfere with school learning (Pynoos,

et al., 1987). With little restful sleep, children are less able to consolidate day learning and keep alert to take in new academic information.

*Miscellaneous symptoms.*

Researchers also present some other symptoms of PTSD that are not captured in the three categories of symptoms outlined by the DSM-IV TR. Miscellaneous symptoms include the development of personality changes, self-injurious and suicidal behaviors, depression/other psychiatric disturbances (Dyregrov & Yule, 2006), somatic complaints like stomachaches and headaches (American Psychiatric Association, 1994, p. 426), separation anxiety (Lieberman, 2004; Yule, 2001a) and academic problems (American Academy of Child and Adolescent Psychiatry (AACAP) Official Action: Practice Parameters, 1998; Hawkins & Radcliffe, 2006).

The presence of auditory hallucinations or "odd beliefs" can be present in children and adolescents diagnosed with PTSD (Kaufman, Birmaher, Clayton, Retano & Wongchaowart, 1997). Percentages range from 9% of abused children from juvenile court or pediatric clinics (Famularo, Kinscherff & Fenton, 1992) to 20% to 76% of sexually abused children on psychiatric inpatient units (Livingston, 1987; Livingston, Lawson & Jones, 1993). PTSD hallucinations differ from hallucinations that are a part of schizophrenia. Hallucinations associated with PTSD do not correspond with typical schizophrenia symptomatology like withdrawn or blunted affect but correspond with impulsive aggressive and self-injurious behaviors, nightmares or trance-like states (Kaufman, et al., 1997).

Further, other researchers discuss cognitive impairments that can accompany a diagnosis of PTSD and interfere with academic and social functioning. Verbal memory

impairments are associated with children diagnosed with PTSD (Yasik, Saigh, Oberfield & Halamandaris, 2006).

*Impingements on Developmental Tasks.*

Erikson's first developmental stage, trust vs. mistrust (Erikson, 1950), shapes how children interact with and engage the world; this stage depends upon both the child's experiences with caregivers and the child's experiences in the world. Mistrust can become a predominant organizing principle when a traumatic event occurs in the beginning or near the beginning of a child's introduction to the world. For young children, these resultant preoccupations with traumatic events interfere with the typical course of development. Skewed thoughts, emotions and behaviors can have an additional impact on long-term development of competencies, conception of self, and interpersonal relationships (Ullman & Brothers, 1988).

As a result of a traumatic event, a child's strivings for autonomy can be dampened. Avoidance of traumatic reminders (Pynoos, Steinberg & Wraith, 1995) can limit a child's normal drive to explore new environments and engage in pleasurable activities. Exacerbated separation anxieties (Lieberman, 2004; Osofsky, 1995) as a result of PTSD can also derail a child's drive toward individuation. A child's self-efficacy might be influenced by others' interpretations (and a child's own understanding) of his or her behavior during and after the traumatic event (Pynoos, Steinberg & Wraith, 1995). Some children emerge from a traumatic event with the sense of themselves as weak, passive, dependent and cowardly.

Normal information processing (Horowitz, 1976) can be disrupted by re-experiencing phenomena of PTSD. If a child either avoids or reenacts traumatic

reminders, then his or her full attention will not be directed toward acquisition of new information. Functional impairments in academic settings can result, with marginal students at the greatest risk for difficulties in school and subsequent losses of self-esteem (Yule, 1991).

The constellation of symptoms—fear, avoidance and hyperarousal--can interfere with mastering skills like affect regulation (Parens, 1991). One of the first steps in achieving the ability to regulate affect requires the ability to differentiate between feelings. Eventually children learn about the origins and consequences of their feelings. However, as noted above, the experience of extreme fear in the case of a child diagnosed with PTSD may interfere with the acquisition of affect regulation, a skill crucial to social functioning. Furthermore, a child diagnosed with PTSD who has unaddressed revenge fantasies might have difficulty containing aggressive impulses and converting them into appropriate assertiveness (Emde, 1991).

Withdrawal from others, emotional constriction and disrupted impulse control, if present in a child with PTSD can interfere with social functioning. Pre-school expectancies include cooperating, sharing and social play and children with PTSD might be excluded from these norms.

*PTSD and Concept of Self*

Several studies have examined the impact of trauma on a child's sense of self (Berntsen & Rubin, 2006; Drapeau & Perry, 2004; Hughes & Barad, 1983; Mannarino & Cohen, 1996; Oates, Forrest & Peacock, 1985; Roesler & McKenzie, 1994). Among these studies there is agreement that PTSD symptoms, as a result of childhood sexual abuse, can include depression (Briere & Runtz, 1988; Browne & Finkelhor, 1986; Stein,

Golding, Siegel, Burnam & Sorenson, 1988), lowered self-esteem (Browne & Finkelhor, 1986), dissociation (Briere & Runtz, 1988; Coons, Cole, Pellow & Milstein, 1990), and substance abuse (Rohsenow et al., 1988; Stein et al., 1988). Mannarino and Cohen (1996) related a child's tendency toward self-blame for negative events to poor self-esteem and depressive symptoms. Another study reports that childhood trauma that is not sexual in nature does not seem to affect self-esteem in a negative way (Roesler & McKenzie, 1994). Given the etiology of one cognitive problem of abuse, i.e. that children blame themselves for the abuse, it has been suggested that successful intervention requires a therapist to provide a safe enough space for children to express their true beliefs about who is to blame for the abuse (Feiring, Taska & Chen, 2002).

Because of their potential interference in the progress and process of typical development, childhood traumas can have long-lasting effects on the development of the self (Pynoos, Steinberg & Piacetini, 1999). For example, children diagnosed with PTSD might conceptualize a traumatic event as their own fault, a belief that can be, without intervention, embedded in one's character. Cognitive development of children can limit a more complex understanding of a traumatic event. For example, a simple world view can lead children to believe that the moon follows them home because it remains in the same position in the sky regardless of a child's location. Likewise, a child can use "anchor events" to define both the state of the world and the self in relation to the world (Pillemer, 1998). Expectancies about the world, beliefs about safety and security begin to map onto schemas of risk, danger and safety. Once these schemas become more organized, they operate automatically, outside of conscious awareness (Cicchetti & Cohen, 1995). When these ideas about the self begin to operate, they can reinforce falsely the "self."

Subsequently, memories of traumas and other negative events validate and reinforce current beliefs and feelings and guide thoughts and behavior (Pillemer, 1998). This attributional style is positively correlated with PTSD symptoms (Greening, Stoppelbein, & Docter, 2002) and trauma memories in PTSD are central to a person's identity and life story (Berntsen & Rubin, 2006), even when studies are controlled for measures of anxiety, depression and dissociation (Berntsen & Rubin, 2007).

*Trigger Events*

Various events can trigger PTSD, including serious illness, natural disasters, criminal assaults (sexual abuse, rape, and other physical assaults), and learning of, or witnessing, criminal assaults or natural disasters. Other events can be "potentially traumatic," such as a parent's being sent to prison or sudden separation from a loved one (Giaconia, Reinher, Silverman, Pakiz, Frost & Cohen, 1995). Pynoos, Steinberg, and Goenjian (1996) discuss other attributes of events that can make them "traumatic." Some of these attributes include: hearing unanswered screams for help or cries of distress; smelling noxious odors; being trapped without assistance; being close to a violent threat; and enduring an unexpected event of lengthy duration. When thinking about a traumatic event's attributes, other factors, such as the relationship of the assailant to the victim, whether or not physical coercion was used, the degree of brutality or malevolence, the frequency of abusive episodes, and the number and nature of threats can add dimensions that help define severe posttraumatic reactions.

Terr (1991) developed criteria to classify the severity of the syndrome. Clinical experience led her to label two typologies of PTSD with two different types of intervention and treatment. Type I childhood traumas are single blows, whereas type II

childhood traumas are long-standing ordeals. Type I traumas fit Anna Freud's definition of trauma (Freud, 1969) and the DSM-III-R criteria for trauma. Type II traumas lead to massive denials, numbings, self-aasthesias or personality problems. Her ideas are supported by other researchers, who note that frequent exposure to the traumatic trigger event is correlated with the severity of symptomatolgy (Pynoos et al., 1987). Mild reactions are associated with apprehension and low levels of anxiety. Moderate reactions to a trigger event include intrusive phenomena and avoidance of feelings. Severe reactions bring out full PTSD symtpomatology, and the most severe reactions bring out estrangement and learning problems.

*Frequency of PTSD in children.*

Epidemiological data reveal that estimates of PTSD among children vary widely. Variability ranges from 10% in the general population (Breslau, Davis & Andreski, 1991) to 40% (Richters, 1993; Richters & Martinez, 1993; Runyon, Faust & Orvaschel, 2002) in children and adolescents from "violent" neighborhoods. One conservative estimate places the rate of development of clinical PTSD at 30% (Perry, 1999).

Rates of posttraumatic stress disorder among children and adolescents are difficult to study, largely because of the different types of populations studied (urban vs. rural) and because of the nature of trauma studied (natural disasters vs. criminal assaults, etc.). Therefore, prevalence of PTSD among children is considered to be a non-generalizable entity. Nonetheless, rates of childhood sexual abuse, physical abuse and neglect are substantial. Overall, 3.6 million children in the United States are reported annually (U.S. Department of Health and Human Services, 2005). Of this number, roughly 900,000 cases are indicated for maltreatment. This estimate does not include cases that are not

reported. According to one study, one in four children will experience a traumatic event by the time they are 16 years of age (Costello, Erkanli, Fairbank & Angold, 2002).

*Psychodynamic Model of PTSD.*

PTSD is not a universal reaction to extreme stressful events. Less than 40% of traumatized adults and children receive a diagnosis of PTSD (Perry, 1999; Yehuda & McFarlane, 1999). While one child might develop the full constellation of symptoms or a partial constellation of symptoms, another child might be asymptomatic. In such instances, the second child's coping/defenses do not lead to re-experiencing the event, avoidance, or increased arousal. Rather, such a child has adaptively integrated the experience and developed "normally" (Pynoos et al., 1999; Yule, 2001b).

This mixed picture of who develops PTSD can be explained, in part, by criteria of the DSM-IV for diagnosis. These criteria have been shaped, in large part, by clinical experience with adults. Frequently children do not meet criteria for PTSD after exposure to a trigger event, yet they have higher rates of psychopathology and other additional impairments (Copeland, Keeler, Angold & Costello, 2007).

A traumatic event evidently affects each individual's personality to produce specific behaviors and unique coping/defensive responses. In psychodynamic analyses these psychological responses are a function of an individual's level of ego functioning. Pynoos, Steinberg, and Goenjian (1996) conceptualize this "link" between traumatic event and personality as a number of "trauma-related expectations." These expectations are often communicated to others as an individual's thoughts, emotions, and behaviors. From a psychodynamic perspective, the thoughts, emotions and behaviors are not a defect in a person's functioning, but rather, an adaptive attempt to manage the traumatic event.

Some children who develop a diagnosis of PTSD experience a breakdown of mental faculties or a change in their coping/defenses (PDM Task Force, 2006; Terr, 1991). Breakdowns may be the result of prior vulnerabilities, as a recent study on antecedents to the development of PTSD suggests. In the study (Storr, Ialongo, Anthony & Breslau, 2007), the presence of anxiety or depression made children more vulnerable to exposure to a traumatic event.

Traumatic stress can lead to difficulty in regulating affect, interference using symbols, impairment managing fantasies related to the trauma (Terr, 1991), sleep disturbances (Terr, 1991) and distortions processing trauma-related memories (Terr, 1991). Lack of sleep and difficulty processing information can lead to the psyche's inability to utilize anxiety and other affects to mobilize the ego's defenses (Krystal, 1988). Primary defenses against the overwhelming traumatic event are paradoxically opposite each other. On the one hand, a child might reenact the traumatic event to master the memories, and concurrently avoid the event and its associated memories (Kudler, Blank, Jr. & Krupnick, 2000). These breakdowns in mental faculties and defenses can lead to behavioral changes and out-of-the-ordinary emotional expressions.

In view of these findings, I am adopting a conceptual model of PTSD in which an individual child's personality interacts with the experience of a traumatic event. The impact of the event on the child's behaviors, thoughts and emotions are a result of changes in the child's coping/defensive strategies. These changes are, in turn, a function of changes in levels of ego functioning as the child adapts to the impact of the experienced traumatic event.

*Review of treatments.*

Studying a treatment of a child diagnosed with posttraumatic stress disorder (PTSD) is one goal of this study. One study (Scheeringa, Zeanah, Myers, & Putnam, 2005) found that without treatment, symptoms and functional impairments associated with PTSD in young children do not remit over time.

Published treatment studies of PTSD in children consist almost entirely of case reports. Some case reports have been eloquent, elegant and deeply helpful to children (Gil, 1991; Lieberman, 2004). Clinical techniques described in case reports have been helpful to clinicians in expanding ideas about how to help children with PTSD. Other clinicians suggest that play therapy is a useful approach in the treatment of children who were sexually abused (Johnston, 1997; Reyes & Asbrand, 2005; Scott, Burlingame, Starling, Porter & Lilly, 2003).

Techniques have been adapted from work with adults diagnosed with PTSD and applied to children. Adapting treatments from adult models has its shortcomings, particularly when the therapist is dealing with children who have been traumatized prior to the development of language. Some of these modified techniques include "prevention/intervention" models. The focus of these interventions is to strengthen and support coping skills to anticipated stressors.

In general, the empirical literature provides more support for cognitive behavioral treatments of PTSD (Deblinger, Mannarino, Cohen & Steer, 2006; Goenjan, Karayan and Pynoos, 1997; March, Amaya-Jackson, Murray & Schulte, 1998; Perrin, Smith & Yule, 2000: Yule, 2001). Cognitive behavioral therapy is framed theoretically by steps to "repair" the trauma: (1) desensitization of trauma-reminiscent stimuli, (2) reduction of

avoidant-related symptomatology. The rationale for these interventions is that they result in more "normal" neurological processing of stimuli (Yule, 2001a). Interventions focus on stress management, relaxation techniques, cognitive restructuring and exposure techniques (Cohen et al., 2000, March et al., 1998). Donnelly, March and Amaya-Jackson (2004) emphasize how critical it is that psychotherapy be effective with very young children diagnosed with PTSD. They claim that ineffective treatments can be a waste of time and that therapists can inadvertently lead a child to retraumatization.

Other researchers have noted an additional obstacle for children with PTSD. The trauma experienced may be retained in the child's thoughts, emotions, behavior and biology as he or she progresses through life's developmental stages (Pynoos 1994; Pynoos, Steinberg & Wraith, 1995). In this way, trauma can alter a child's inner conceptual organization of the self, the world, and other people. Also, internalized traumatic organization predisposes children with PTSD to the risk of experiencing repeated trauma. Depending upon a child's individual circumstance, it may be that trauma remains a lasting scar without any cure (Terr, 1991), or perhaps, with some children, it is a condition that can be attenuated via appropriate interventions.

Cognitive behavioral therapy may not be the most appropriate therapy for younger children. Several obstacles to its potential as a therapeutic tool are presented by early developmental levels (Salmon & Bryant, 2002). Young children may not be able to understand the rationale for re-exposure to the traumatic stimuli; they may not be able to focus for sufficient periods of time; moreover, they may be further traumatized by traumatic images. If they are unable to regulate their anxiety, these children may not be able to use cognitive strategies to modify their mistaken beliefs or distorted thinking.

The utility of cognitive behavioral therapy for managing PTSD in very young children has not been fully researched.

Play therapist Eliana Gil locates herself in the middle of the debate over treatments for children with PTSD, in which one side pushes for techniques backed by scientific research and the other backs a psychoanalytic approach that is more of a clinically evolved art form. Gil (2006) argues that the best types of treatments consider the needs and circumstances of each individual child and balance scientific and artistic approaches to therapy. While few studies validate the effectiveness of interventions with abused and traumatized children (Miller-Perrin & Perrin, 2007), psychodynamic approaches to treatment of PTSD in children offer the promise of developing sound theory to support the use of play activity in child treatment.

Play activity can be a useful medium for therapeutic intervention. If one purpose of play activity for children is to help them work through an event (Schaeffer, 1994), then play activity after a traumatic event has implications for the development of self schemas. Schaeffer (1994) suggests that the concept of *abreaction* is based on a strong impulse common to all human beings to recreate and repeat an experience as a way to assimilate it. For children, repetition may involve play activity. Play activity may also serve to help children develop mastery of difficult events, develop the ability to regulate affect or reduce arousal, and begin to make meaning from chaos (Marans, Mayes, & Colonna, 1993).

Some trauma interventions (Cooke-Cottone, 2004) that are beginning to show more empirical support include play, art, narrative therapies and psychopharmacology. Play and art therapy occupy a unique place in the field of treatment as young children,

like my subject, who were exposed to trauma at a preverbal age, might more readily express themselves through nonverbal modalities (Johnston, 1997; Kozlowska & Hanney, 2001; Osofsky, 1995). Other researchers observe shared features between cognitive behavioral therapy and play therapy in allowing young children to do what more verbal children might be able to do through talking with a therapist. Play activity, however, reaches beyond cognitive restructuring. It can potentially empower a child to repeat previous traumatic events and to fundamentally restructure their experience on three different levels of functioning: bodily, affective and cognitive (Ryan & Wilson, 2000). Nondirective play therapy differs from cognitive behavioral therapy in that therapy goes at the child's own pace and focuses on the child's own curative potential along with a therapist's unconditional positive regard and empathy (Axline, 1976). Ryan and Wilson (2000) report that through the use of a non-directive play therapy stance, the child's PTSD symptoms ameliorate.

I am postulating that with supportive expressive psychodynamic interventions, the child's play activity, behavior, and concept of self will change in the following ways:

(1) His play activity will reflect his developing sense of self and help him to make meaning of the traumatic experiences. These changes will be reflected in scores of his play themes, changes in coping and defense mechanisms, and increasing self-awareness of himself as a player.

(2) His self-esteem will "improve" as evidenced by changes in scores from baseline to post-study on the Self Perception Profile for Children (SPPC) (Harter, 1985).

(3) His acting-out behaviors at school and at home will decrease as evidenced by changed scores from baseline to post-study on the Child Behavior Check List (CBCL) (Achenbach, 1966).

# CHAPTER II

## BACKGROUND INFORMATION

Joshua is a 9-year-old African American male referred for treatment in the summer of 2003 by a staff psychologist who was treating his older sister. At the time, his grandmother described him as "clingy" and "oppositional." She reported that he had difficulty sleeping, missed his mother and had been sexually abused.

When I first met Joshua, he was curious and interested in exploring every corner of my office. He definitely had preferences for animal toys or action figures, yet he thoroughly explored every box of toys and every shelf my closet. I was struck by his ability to create epic play narratives with disturbing themes. Early in my work with Joshua, I made it a point to carefully record my sessions as true to what happened because I found his themes confusing and worried about my own reaction and feelings to disturbing themes.

Physically, colleagues described Joshua as "adorable" and "cute." His diminutive stature, cherubic face and big brown eyes did not prepare one for some of the words that came out of his mouth. Once he made action figures fight and say to another, "Do you want a piece of me?!"

I heard that he was very "clingy" to his previous therapist and that he might have trouble with the transition. He mentioned her several times in my presence and often

compared us to each other. When given the opportunity to discuss his relationship with his previous therapist, he did not wish to.

Joshua has had a difficult relationship with his maternal grandmother (legal guardian). While she has provided materially for him and has been a staunch advocate for his academic success, she has taken his rejecting comments personally. He has now and then threatened to leave or run away and has told her that he wanted to live in a hospital. When this has occurred, she has threatened to send him to foster care.

Background

Joshua's historical information was collected from his current legal guardian, his maternal grandmother. When I first met her, it was apparent that she was concerned about him. She consistently met me each time I requested a meeting, and she followed through on recommendations including a parenting group. As I have worked with her over the past 4 years, I have learned that she is anxious and quick to react negatively toward her grandson when he misbehaves. I observed her tendency to portray events as more catastrophic than a teacher or a sibling. I also experienced her as overly punitive in her management of Joshua's behavior.

When Joshua was 22 months old, he and his older brother came to live with his grandmother in New York City. The two children joined their 8-year-old sister who was already living with her. His grandmother reported his abnormal behaviors and appearance: he "humped objects" while on his stomach; he was unkempt and unclean; he ate as if he weren't fed on a regular basis; and he danced and clapped when it was mealtime. Later his grandmother learned that he had been fed oatmeal three times a day and was force-fed when he refused to eat it.

A social worker alerted the grandmother that her grandchildren were being abused. Joshua was reportedly hit so hard that he was almost knocked out. Once he reportedly clung to his mother, who knocked him off of her chest. He cried and tried to get back on his mother's lap. In addition to the abuse, Joshua was exposed to guns and physical fighting between his parents in their Detroit home. Once Joshua and his brother witnessed their maternal great grandmother shoot at their mother with a gun. The children also witnessed their mother and other family members drunk.

His grandmother saved her grandchildren from ending up in the foster care system. She brought both grandsons, with cuts and wounds on their faces, to live with her in New York City.

I began seeing Joshua in the fall of 2004. He was transferred to me from a therapist who had seen him for roughly one year. Prior to my work with him, he was sent to the hospital to be evaluated for psychosis. He reported hearing voices, but he was released from the hospital, and antipsychotic medication was not recommended.

Family configuration

Joshua is the middle of three children. His older sister has a different father, who has consistent contact with her. He and his older brother share the same father and mother, and they both lived in Detroit with their parents for a longer time than their older sister. Joshua and his brother were exposed to the family chaos for a longer period of time than their sister. Joshua's older brother currently lives in a residential treatment facility because his behavior became difficult to control for his maternal grandmother.

Little is known about his father except, on his maternal grandmother's suspicion, that he molested Joshua's older brother while living in Detroit. His father was reportedly

in and out of prison for drug-related charges and for murder. He also was physically abusive to Joshua's mother and sexually inappropriate with his children. He reportedly routinely kissed his oldest son on the mouth and genitals. Joshua's brother reportedly laid on top of him and groped him after they moved to New York City.

Joshua's mother was the oldest child of three born to his current legal guardian and caregiver, his maternal grandmother. She was born with spina bifida and received speech therapy, physical therapy and psychotherapy until the 7th grade. She wore a prosthetic device and limped around. She also was born with two fingers on one hand and developed scoliosis. Joshua's grandmother reported that she was difficult to manage, oppositional and disrespectful of her authority in the house.

Joshua's uncle had a history of substance abuse (alcohol, marijuana and angel dust) and was also arrested. He later developed schizophrenia and was also accused of sexually abusing Joshua's sister and cousin. He reportedly groped their private parts.

Joshua's maternal grandmother is devoutly fundamentalist Christian. Her religious beliefs shape how she views her grandchildren's behavior. Religion is used as a tool to help guide her parenting.

Functioning at home and school

When I first began working with Joshua, he was enrolled in a Catholic private school in the kindergarten. He performed in the average range in all of his classes except for science, in which he excelled. He seemed to benefit from the structure of the classrooms. After the first year, he began public school in the first grade and had difficulty adjusting to the environment. His guardian removed him from school toward the end of the year because she reported that the teacher was verbally abusive to the

students. This same complaint was made by several parents. He was home-schooled for the remainder of the year, and his grandmother had hoped to accelerate him so that he could enter a gifted program.

Joshua struggled when he returned to public school in the fall and was behind his peers. He had behavioral difficulties that included oppositional behavior. He reported that other children picked on him and he himself became physically aggressive, once throwing a piece of furniture. He became physically violent with his teacher, and was suspended and sent to another school for two weeks. He returned to his home school after the suspension and was transferred to a bilingual classroom with a new teacher who set firmer limits than his previous teacher. He thrived for roughly 8 months, and then his behavior problems returned. He ran out of the classroom without permission, became physically aggressive with peers and cursed at his teacher. After a school meeting with the principal and his teachers, his behavior problems subsided.

Transitions to summer camp have also brought difficulties for Joshua, and he has reported that he misses his mother. (Joshua's mother has visitation with him that has been sporadic and supervised when her behavior has gotten out of control in his presence.) Currently Joshua does not have any scheduled or supervised visits with his mother.

Pre-study sessions with Joshua

*The function of play activity.*

Joshua used play activity for several purposes: (1) to master real-life situations, (2) to integrate, conceptualize and organize his experience, (3) to express feelings, and (4) to represent aspects of his world. In my early sessions, Joshua used play activity to

master transitions, to understand social conventions and rules, to tolerate his separation from his biological parents, and to understand the concept of adoption.

In general Joshua had difficulties with transitions: from therapy sessions to his grandmother's apartment; from grade to grade in school; and from season to season (spring to summer). During one session shortly after he met me, he announced that he wanted to stay in my office forever and ever. Transitions were fraught with regressive behavior (i.e., baby talk, crawling into my closet, etc.) or with oppositional behavior (i.e., refusing to leave my office, refusing to let got of toys, disobeying his grandmother, etc.). Then in one session, he created a scenario in which a mother set firm limits to make her son go home. In the play scene, the boy refused to go home and repeatedly tantrumed after his mother set limits.

Joshua's play activity empowered him. Through play he was able to assimilate social conventions, rules and consequences. Prior to one session I learned that he had gotten punished for breaking his sister's CD player. Subsequently he created a scene in which a principal and student reversed roles so that he was the principal. He instructed the therapist to misbehave and then, as the principal, called the boy's mother to have him disciplined for breaking another student's CD player.

Through play activity, Joshua asked questions: what it meant to belong and how motherless children find their way in the world. Most typically, Joshua created interactions between a boy and his mother. The boy often asked permission from his mother to travel away from her with strangers, usually other species of animals or beings with super-human power. Once he got to know me better, his family configurations changed from a duo to a trio. He also "played" with the explanations for the absence of a

father in his life. Play activity focused on an absent father who was at work, who died or who was gone (no explanation). Sometimes in Joshua's play activity, characters were united with their fathers. In one scene, a boy went to a gift store and met a fatherless baby zebra. The boy adopted the zebra. Then the zebra was somehow united with his father who took him to a wild jungle. The boy, fatherless himself, asked the baby zebra's father to be his father as well. The zebra's father declined because humans and zebras are from different species. Joshua's preoccupation with belonging emerged in some play activity organized around adoption themes.

Not only did play activity function to help Joshua ask questions or "play" with what it meant to be a member of a group or a family, he also used play to express emotions, or to see his therapist express and label emotions to characters in play sequences. Some situations in the play activity brought emotional reactions to the characters. Joshua created a scene in which a boy, raised solely by his mother, became envious of another boy who had both an uncle and a father. Other times during our sessions together, Joshua wanted me to make characters angry at each other or to be saddened by events. In particular, when a mother's children were hurt, Joshua asked me to make her angry.

Some play sessions clearly mirrored the Joshua's life and, I believe, represented his world. Reality intruded on Joshua's play activity. In one scene, a boy was jailed, whipped and beaten. His mother called him "evil" and left him in jail. Then she decided to adopt another boy, the boy's sister, and her cousin to live with her. After she put the children to sleep, the boy emerged from his jail cell and spent the night with his brother. They whispered to each other how much they missed each other, and the newly adopted

son got leftover dinner for his brother in secret. Joshua has an older brother who was placed in a residential treatment facility because his behavior was often aggressive and out-of-control. His grandmother has often called the behavior "evil" based on her Christian beliefs. Joshua also lives with his sister and frequently has visits from his cousin.

Sometimes Joshua's play activity confounded me completely, and the meaning of his play was unclear, yet I still believed it represented his past experiences. I became anxious, confused and troubled to the point that I dreaded his chaotic, catastrophic play themes that usually arose near the end of our sessions as he was anticipating separating from me. When sessions were more disturbing, I found myself struggling to remember what took place in the sessions with my supervisor. I spent double the amount of time I usually spend trying to piece together the details of the play for my process notes. I wondered if it was possible that what I felt—the anxiety, confusion and discomfort—were feelings that Joshua felt at some point during his play activity and during his daily life as well. This is how reality intrudes on the play of PTSD children through regulation of affect.

Joshua portrayed affective experiences in his play activity in defensive ways. One recurrent theme concerned Joshua's labels of inappropriate affect of the characters in his play scenes. Several times in the first year of therapy, he became annoyed at me when I guessed what affects to attribute to certain characters in emotional situations. When a boy was not allowed to play with some trains, the therapist made the boy sad, but Joshua wanted the therapist to make the boy happy; years later I understood this to be a coping strategy called reversal of affect. Rather than tolerate the feelings of an event,

Joshua replaced the feeling with an opposite feeling; in this case a bizarre opposite feeling. In this manner, he was able to keep the upsetting idea and feeling away. After I complied with the directive, Joshua whispered to me to make the boy miss his daddy. Reversal of affect resurfaced months later when a mother did not let her boy spend the night with friends and Joshua instructed the therapist to make the boy happy. In another scene, a comic book character beat and killed a boy's mother with one blow of his fists. Joshua instructed me to make the boy happy that the character (Hulk) beat his mother. Then the Hulk invited the boy to live with him.

When sessions were disturbing to me, the play activity usually had morbid qualities and fantasy elements that were not based in reality. The play activity had dream-like sequences that did not appear linked to each other and often contained incongruous elements. Most of the time when the play activity most disturbed me, I found myself feel sad or anxious because of the content of the play.

Most upsetting were the catastrophic events with no resolution that occurred near the end of our sessions. In one example, a boy went on a journey in search of his father. He asked for help from firemen who ignored him and fed ice cream to others except for the boy. When the boy got to the front of the line, the ice cream was sold out, and the boy was punched in the face and sent to the hospital with blood on his face. Most often these sequences occurred right at the end of our sessions. It is possible that separation from a therapeutic space also caused Joshua some distress and that he continued to work on issues of object constancy with his therapist.

Some play activity did not appear to alleviate anxiety, and chaos overtook mundane, everyday scenes. Some chaotic scenes included incongruous events, like

interrupters to the flow of play activity. This type of traumatic play activity usually occurred near the end of sessions. For example a bulldozer plowed over the little boy, and his mother brought him to the hospital. Even though the police were involved, no consequences or recourse for the bulldozer occurred. Then the focus changed abruptly to a bloody frog who made frog noises and jumped into the scene. Joshua explained to me that when the blood on the frog touched anyone, they died because it was poisonous. The frog then challenged each character in the play scene to a fight. He killed off each character. Catastrophic endings were repeated in different variations through the course of treatment. Some of Joshua's darkest scenes went on and on without hope or rescue. In one scene late in the first year, Joshua created a story in which a boy was buried in the sand. Joshua asked me to make the boy like his burial. When I stated that the boy could not breathe, he laughed. When the mother attempted to rescue the boy, Joshua threw her across the room. Then he announced that the boy died in 1999 and that some man came into his apartment and shot him. He instructed me to make the mother pray for him.

Objects also easily transformed so that they were not always represented realistically by the play objects: a rhinoceros turned into a "rhinoceros whale" and swam with another shark in an aquarium, a hammerhead shark drove a bus. In the same session a sea anemone and a hammerhead shark went to a club in the sky to eat cake. Later the sea anemone's tentacles began to bleed and he went to the hospital. In subsequent scene, a character named "Mrs. Purse" kicked a sea anemone, then got kicked in the stomach and they were forced to get married. While objects more or less resembled the characters that Joshua created (the sea anemone was a rubber stress ball with noodles extending

from it), Joshua's use of them was colorful and creative. The play objects that Joshua used were under his voluntary control.

Characters were also not what they seemed to be, so that their appearance did not predict their behavior. A doctor was a crocodile. Best friends (sharks) swam in aquarium tanks and it was safe for children to swim with them. In one session, Joshua created a scene in which a friendly lion killed an elephant and ate from its belly. Early in treatment, Joshua created other scenes in which parents told children that the wild jungle animals were friendly and safe in spite of their teeth and claws.

Themes

Joshua created adoption themes throughout the first year of treatment. Joshua in his play activity repeated the theme of poor supervision of children, a lack of parental structure/nurturance, and wild children. On more than one occasion, a mother and the little boy invited different species of animals home with them to live. In one play scenario, two twin tigers lost their mother, who had abandoned them. The two tigers announced the absence of their mother, drove around in a bus recklessly, clawed and killed a crocodile, and began to eat it. Then they killed the boy's mother, who watched the scene without any emotional response. Finally, the two tigers reunited with their family, a rhinoceros father and a hippopotamus mother. The two young cubs that were adopted by a boy and his mother requested an adult zebra for breakfast instead of what their mother wanted to serve (cereal). They told their mother that they wanted to claw the adult zebra so that it bled before they ate it.

In this play scenario it seemed that Joshua's adoption by his grandmother may have been symbolized by the family configuration of non-biological parents. Joshua also

appeared to equate the absence of parents with wild, destructive behavior. Yet in the new family, the cubs still have their wild instincts and choose to eat animals instead of the food their adoptive mother offers them.

Absent and neglectful friends and parents also populated Joshua's play themes. During one session, the little boy attempted to get the attention of his pet shark, who told the boy that he missed his own mother. In another scenario, the boy wanted to play with a model of Thomas the Train, but Thomas was working and then got sick, so he was not able to play with the boy. As a result, the boy became disappointed and upset. Parents were often absent in Joshua's play scenes and when present, they were unable to protect against dangers, lacked judgment about safety, or misdirected young members of families as to whether or not safety existed. Play activity included parents advising children that wild animals were safe despite their carnivorous nature: parents guided children into wild jungles or advised children that they could swim with dangerous sharks without any safeguard.

Safety was often not present in Joshua's play activity, in contrast to the safe haven of his play space, and personal boundaries were violated as if normal. Sexual boundaries were often violated. Joshua created scenes in which characters licked one another to denote fondness for another. In an early scene he had a girlfriend character kiss a boyfriend character on the eye and the boyfriend character did not like it. Joshua encouraged me to have a little boy take off his shirt before being with the crocodiles so that they didn't kiss him. The boy healed the crocodiles after they bit each other on the mouth hard enough to cause bleeding. Then when the boy healed them, they kissed him. Joshua later created a character called the "ooey gooey" monster with an "ooey gooey"

tongue that licked people. He said that the monster "might lick the boy and the boy might get stuck on the tongue." He also located the monster's "wee wee" near the monster's crotch.

Themes of adult activity emerged several times in the first year of treatment. Joshua created a scene in which adults were not allowed in a clubhouse. One of the clubhouse rules was "no drinking." Later in the same session, Joshua had two children drink and watch adult movies together for entertainment. He called them "evil." The mother attempted to save the little boy in the clubhouse, but she was thwarted by a tongue that wrapped itself around her and threw her across the room. Joshua reported that a frog was responsible for all of the evil. In a subsequent session two weeks later, Joshua created a scene in which a boy was hurt by some burning fluid and was rushed to the hospital by his mother. His doctor, a crocodile, took the boy to drive race cars. The boy questioned the doctor whether he (the boy) was old enough to drive.

Defenses in the play activity

I have already mentioned Joshua's use of reversal of affect to defend against unwanted affect. In addition to the numerous themes of injury, Joshua created alternative explanations for the destructive behavior by characters in his play activity. A whale hurt a boy with his tail not because he is "bad" but because he had nobody to take care of him. The boy's mother subsequently took care of the whale (projection).

Furthermore, through his play activity, I wondered if Joshua was trying to communicate not only how dangerous the world is, but how to manage it: sharks tried to bite a little boy and a boy got hurt by sticking his hand in a fan. To balance the danger, Joshua created superheroes whose strength was unparalleled by any other character

(introjection). Once Joshua came into my office and flexed his muscles to show his strength to me. Then he had one superhero mentor another in how to fight every evil doer in his play scene (identification with the aggressor). In this manner, Joshua was able to keep his feelings of anxiety and vulnerability at bay. Joshua also created a superhero who was independent; he stated to me, "superheroes do not have mothers" (intellectualization and rationalization).

In addition to family themes, Joshua's play also included social themes with non-family members who either included or excluded characters. After a friendly gesture, one character did not want to play with the boy because they were bullied by others to exclude the boy. In another session, two characters rode a ferris wheel that could only hold two people and excluded the boy. In other scenes, the boy looked on as two friends had fun together, eating cakes or driving cars. Often times, the little boy was not allowed to participate because of signs that banned his inclusion.

Joshua's play activity was chaotic and often strange. At times it may have served to organize him and at other times I wondered if his play activity unconsciously communicated to outsiders by exposing the therapist to traumatic events, thereby sharing the traumatic experience and potentially gaining from the ego strength of the therapist at the moment of re-exposure and from the context of a safe haven of the therapeutic space.

# CHAPTER III

# METHODS

## Research Instruments

### Children's Play Therapy Instrument-Adaptation for Trauma Research (CPTI-ATR)

The Children's Play Therapy Instrument (CPTI) was developed in 1997 to analyze a child's play activity in individual psychotherapy (Kernberg, Chazan. & Normandin, 1997). The Children-s Play Therapy Instrument-Adaptation for Trauma Research (CPTI-ATR) (Cohen & Chazan, 2003) is an adaptation of the CPTI for children who have been exposed to trauma (Appendix A). The scale includes the following subscales: child's affective expression, narrative themes of the child's play activity, interactions between the therapist and the child, developmental and social levels of play activity. In addition, the scale identifies strategies for coping with or defending against the experience of traumatic exposure. The strategies observed in a child's play activity range from adaptive to increasingly maladaptive and defensive. Depending upon the child's repertoire of coping/defensive strategies, his play activity is described as: (1) Re-enactment with Soothing, (2) Re-enactment without Soothing and (3) Overwhelming Re-experiencing. These clusters may overlap, as they are not mutually exclusive categories.

Children rated with attributes of the first cluster (Re-enactment with Soothing) use play activity to re-enact aspects of the trauma for relief and closure. The play activity serves the function of providing anticipation, problem-solving, sublimation, affiliation,

humor, suppression and altruism. Children rated as having attributes from the second cluster (Re-enactment without Soothing) also use play activity to re-enact disturbing aspects of the trauma; however, coping/defensive strategies observed do not result in relief and closure. Aspects of their play activity may include identification with the aggressor, projection, splitting, omnipotent control, acting out impulses, devaluation, doing and undoing, introjection, repression, regression, negation, turning aggression against the self, reaction formation, isolation, intellectualization, avoidance, or denial. Play activity strategies included in the third cluster (Overwhelming Re-experiencing) reflect the child's helplessness and inability to play constructively. These children become so overwhelmed by their feelings that they lose control of the play activity and of their actions. This overwhelming re-experiencing usually gains momentum and ends with an interruption of ongoing play activity. Strategies observed in this cluster include: de-animation, constriction, freezing, de-differentiation, dispersal, autistic encapsulation and dismantling.

The following scales of the CPTI-ATR were used in the study. In the Descriptive Analysis of Play Activity, I used the Overall Level of Contribution of Participants (Passive and Active). In the Structural Analysis of Play Activity, I used the Regulation and Modulation of Affects and the Appropriateness of Affective Tone to Content scales. In the Cognitive and Dynamic Components of the Play Activity Segment, I used Stability of Representation scales (People or Persons and Play Objects). In the Developmental Components of the Play Activity Segment, I used Psycho-Sexual Phase Represented in the Play scales. Finally, in the Functional Analysis of the Traumatic Play Activity, I used the Traumatic Play Strategies scales.

Overall excellent reliability (Cohen & Chazan, 2007) has been reported by the authors of the scale. Using Kappa, reliability ranged from 1.00 for segmentation, to .83 for specific affects, to .79 for reenactment without soothing. Validity was demonstrated by the differences in play profile between children exposed to trauma as compared to the play profiles of children not exposed to trauma. In general, the authors found that children exposed to trauma exhibited more "acting out" externalizing themes and less awareness of themselves as players than their non-exposed peers.

Self-Perception Profile for Children (SPPC)

Harter (1999) conceptualized self-esteem as a system based on the difference between one's ideal vision of the self and one's perceived real self. Those with a small discrepancy have high self-esteem. The scale was based on the idea that individuals continuously compare themselves to their contemporaries in different areas of functioning and accordingly adjust their self-esteem. Harter chose to conceptualize a child's self-esteem according to 5 domains of functioning.

Each of the domain areas assessed is the result of a model of self-competence conceptualized by two theorists, Cooley and James. James (1892) believed that self-esteem or self worth could be calculated from a formula: self-esteem = success divided by one's aspirations or ambitions. Cooley (1909) believed that self worth represented an incorporation of attitudes of others towards the self. Harter's (1985) model is based on both theories.

The SPPC (Harter, 1985) is an instrument/scale that contains six separate subscales that tap into five specific domains and one global domain; the specific domains include: (1) Scholastic Competence, (2) Social Acceptance, (3) Athletic Competence, (4)

Physical Appearance, (5) Behavioral Conduct (Appendix B). The scales represent a child's judgments of his or her own competence and feelings of self adequacy. The questions do not directly assess a child's competence in terms of actual skills. The scale used in this study was written for children between the third and sixth grades.

The Scholastic Competence scale taps into a child's perception of competence or ability in academic realms. The Social Acceptance scale taps into the degree to which a child has friends and feels popular among peers. The Athletic Competence subscale taps into perception of self related to sports and outdoor games. The Physical Appearance subscale taps into a child's satisfaction or happiness in the way he or she looks (height, weight, body shape, face, hair, etc.). The Behavioral Conduct subscale taps into a child's view of his or her own behavior; e.g., whether the child does the right thing or avoids getting into trouble. The Global Self-Worth scale taps into whether or not a child likes him or herself. Harter's (1985) approach of identifying specific domains of self-worth differs from questionnaires or measures that ask children to make a global judgment about their self-worth. Each domain is assessed directly and independently from one another rather than constituting an aggregate sum of answers for global self-worth.

Questions were designed so that a child would be less likely to answer the questions in a socially acceptable way. They were posed so that children identified which description of another child or group of children best fit them.

The SPPC has been used before in developmental and social developmental research studies (Cairns, McWhirter, Duffy & Barry, 1990; Hoare & Mann, 1994; McSheffrey & Hoge, 1992).

The reliabilities on all six scales using Cronbach's Alpha fall within acceptable limits. Correlations for specific domains were: Scholastic Competence .80 to .85, Social Acceptance .75 to .80, Athletic Competence .80 to .86, Physical Appearance .76 to .82, Behavioral Conduct .71to .77, and Global Self-Worth .78 to .84 (Harter, 1985).

Child Behavior Check List-Teacher's Report Form (CBCL-TRF)

The CBCL (Achenbach, 1966) was designed to assess the behavior and social competence of children according to teachers or parents (Appendix C). It is a norm-referenced behavior rating scale. Parents or teachers are presented with a list of behavioral problems and competencies and asked to rate the degree to which statements are true. Categories of behavior assessed include affective problems, anxiety problems, somatic problems, ADHD problems, oppositional defiant problems, and conduct problems. In this study, was used to measure the change in behavior over time. One set of questionnaires was given to Joshua's grandmother and one to his primary school teacher pre-intervention. The same questionnaires were repeated post-intervention.

The CBCL has been studied (Saigh, Yasik, Oberfield, Halamandaris & McHugh, 2002), and variations in CBCL scores have been associated with PTSD but not associated with children who have experienced stress without developing PTSD. The researchers found that children in the PTSD group were rated by parents as having higher Anxious/Depressed, Somatic Complaints, Withdrawn ratings, Attention Problems, Thought Problems and Aggressive Behaviors.

A reliability study (Achenbach, 2001) using the CBCL revealed individual item interclass correlation of greater than .90 obtained on data collected from mothers, mothers and fathers, and interviewers who administered the scale. The stability of the

interclass correlation for behavior problems was .84 and .97 for social competencies over a three month period. Test-retest reliability of mothers' ratings was .89. The instrument was found to be well standardized with adequate validity (Satteler 1992).

Participants

Joshua, a 9-year-old African American boy, and his maternal grandmother are the participants. Joshua has the diagnosis of PTSD. This research is an individual case study of one child and one therapist. It is not my intention to generalize results, but to observe and measure the psychodynamic aspects of play activity intervention. Joshua and his grandmother were involved in history gathering. She gave written consent to videotape 3 therapy sessions of her grandson's play to be used in this research. Every attempt has been made to maintain confidentiality during the course of the study and to continue treatment without disruption.

Sessions were rated using the CPTI-ATR (Chazan & Cohen, 2003). The CBCL-TRF was administered pre- and post-intervention. Joshua was interviewed by the therapist for pre- and post-test measures on the SPPC. In addition, copies of the CBCL-TRF and SPPC were given to Joshua's teacher.

I scored the CPTI-ATR and discussed the results with Dr. Saralea Chazan, one of the authors of the scale.

Procedures

The CPTI-ATR (Chazan & Cohen, 2003) was used to analyze the play activity of my patient, Joshua. I used the scale to study the process of treatment following 2 months of work. Specifically, I examined the following areas of play activity: child's contribution in the play activity, child's regulation of affect and appropriateness of affect,

child's representation of play objects and people in the play activity, psychosexual phases and traumatic play strategies. Three ratings were taken at the beginning, mid-point and end of the course of the three months of research intervention.

I chose to measure self-perception of a child in therapy to investigate how the measure would change as a result of therapy. In this study I examined the relationship between self-perception (self-esteem), play activity and behavior.

I used the CBCL-TRF to assess how internalizing and externalizing behaviors are related to a psychodynamically-informed play therapy intervention.

*Data Analysis*

Three data streams were collected from the study. These data streams are: Differences in the Self Perception Profile for Children (SPPC), Differences in the Child Behavior Checklist (CBCL) and Differences in the Children's Play Therapy Instrument (CPTI-ATR) pre-intervention and post-intervention. Pre- and post-intervention results were compared via visual difference in graphs, and a statistical analysis was conducted to determine whether or not some measures on the CPTI-ATR changed together.

In addition to quantifiable results, a qualitative analysis was undertaken to describe in narrative form aspects of Joshua's evolving play activity.

It is assumed the scales selected to measure behavior (internalizing and externalizing) and self-perception (self-concept) identified crucial child attributes that account for the emergence of symptoms underlying PTSD. It is assumed the CPTI-ATR measures aspects of the traumatic exposure as revealed in the child's play activity and subjective perceptions of the event. This measure also assesses attributes of play activity associated with the child's personality development and change.

Hypotheses

I proposed that with supportive expressive psychodynamic interventions, Joshua's play activity, behavior, and concept of self would change. Specific hypotheses included:

Hypothesis 1: Over the course of the treatment, play activity will be more adaptive, provide comfort, and resolve earlier issues of risk and danger. Joshua will be able to self-soothe enough in sessions through play activity to provide resolution.

i. Adaptive play will be reflected in the descriptive analysis of play activity by ratings of considerable evidence for his active participation and facilitation in the play activity.

ii. Adaptive play activity will be reflected in the affective components of play activity over time in increasing evidence of regulation and modulation of affects and appropriateness of affective tone to content. Further, Joshua's play activity over the course of treatment will be observed to demonstrate increases in stable representations and in voluntary transformations of play objects and people as opposed to involuntary transformations of objects and people.

Rationale: The ability to self-soothe in play activity is partly determined by a child's active facilitation of play. Active participation includes the ability to regulate and modulate affect along with affect appropriate to context. To use play activity to self-soothe implies that a child will not be

so overwhelmed that he is unable to voluntarily transform play objects into what he or she intends.

Hypothesis 2: Developmental components of play activity will reflect fewer regressions over time and an age-appropriate developmental level. Psychosexual stages represented in the play activity will have predominantly oedipal and latency components.

Rationale: One of the symptoms in children diagnosed with PTSD is regression to earlier developmental levels. A lack of regression or a progression to age-appropriate developmental levels can give an indication of the effectiveness of supportive and expressive psychodynamic interventions.

Hypothesis 3: A functional analysis of the play activity will show an increasing use of predominant ratings in Cluster One: Re-Enactment with Soothing. Cluster One includes the following coping/defensive strategies: anticipation, problem-solving, sublimation, adaptation, affiliation, humor, suppression and altruism.

Rationale: I am assuming that supportive and expressive psychodynamic interventions will help Joshua utilize the play activity in a productive way and that it will provide self-soothing for him. I also expect to see him use predominantly the coping/defensive strategies associated with Cluster One: Re-Enactment with Soothing.

Hypothesis 4: Joshua's self-esteem will "improve" as evidenced by changes in scores from baseline to post-study on the Self Perception Profile for Children (SPPC) (Harter, 1985).

Rationale: PTSD can affect a child's self-esteem. Measurement of Joshua's self-esteem before the inception of this study as opposed to three months later can give an indication of the impact of supportive and expressive psychodynamic interventions on self-esteem.

Hypothesis 5: Joshua's acting-out behaviors at school and at home will decrease as evidenced by changed scores from baseline to post-study on the Child Behavior Check List (CBCL) (Achenbach, 1966).

Rationale: PTSD can affect a child's self-esteem. In addition children can internalize ideas about themselves, for example; "This bad event occurred, so I must be bad." These types of ideas can affect behavior. Measurement of Joshua's behaviors before treatment as opposed to his behaviors after treatment can give an indication of the effectiveness of supportive and expressive psychodynamic interventions.

Supportive and Expressive Psychodynamic Interventions

Two different types of interventions were used in the treatment of this 9-year-old boy. The psychodynamic treatment can be described as having a supportive component and an expressive component. This modality of treatment (SEPP) has been described by Paulina Kernberg and Saralea Chazan (1991) in their book Children with Conduct Disorders: A Psychotherapy Manual.

Supportive interventions include: education, therapist's suggestion and encouragement, reassurance, and empathy. Educational interventions serve to supply factual information and to teach new skills. Therapist's suggestions are ideas that invite alternative courses of action a child could take. In this manner the child's ideas of alternative possibilities expand his or her problem-solving ability. Encouragement invites the child to repeat an approved action; reassurance suggests that the therapist also approves of the child's thoughts and actions. Empathy refers to the therapeutic act of resonating to and labeling affect, thereby increasing the understanding of the child's feelings.

Expressive interventions include: clarification, "look-at" and "see-the-pattern" statements, and interpretation. Clarification and "look-at" statements help the child understand the connection between actions and consequences and between actions and feelings. These statements refer to behavior taking place in the session or outside the session. Finally interpretation, another expressive intervention, suggests new meanings that help to alleviate the child's experience of conflict and anxiety.

***Examples from treatment excerpts***

A supportive intervention occurred in the last of three sessions. Joshua enacted a scene of bullying. One character concocted a plan to deal with the bully:

**Therapist**: That is so smart. Come on…
**Child**: Even though you guys used to bully me and tell me that I'm weird, I came up with a great plan.
**Therapist**: Maybe sometimes smart people can solve things better than bullies can (to the other tiger). Maybe your're right, I hope this works.
**Child**: Go now! (tiger goes to distract Godzilla)

This supportive intervention validated and reinforced Joshua's thought to outsmart instead of outmuscle the bully and suggested a more effective way of coping with threat.

Another example of a supportive, educative intervention reinforced the rules of the world to Joshua when he enacted a scene between two friends who mistreated each other:

**Therapist**: Your brother, I know. Doesn't know how to manage his behavior. Then he's giving people wedgies. Come on! Friends don't do that to each other.

Here I acted with the knowledge that Joshua has trouble with social interactions and I experimented with introducing the conventions of friendship to his play activity.

Another example of a supportive intervention, modeling self-reflection and exploration, occurred in the first taped session:

**Therapist**: You haven't played with that before have you? (Child is playing on an etch-a-sketch-type board)
**Child**: Uh, uh (Pt. is drawing on a board)
**Therapist**: You're experimenting with what the shapes do on that.
**Child**: What? What do they do?
**Therapist**: Why don't you check and see?

Here the therapist encouraged the child to experiment with the drawing board.

Expressive interventions included my attempts to engage Joshua's affective experience of his own play activity. Several times during the play activity I asked him what feelings to attribute to certain characters, and I also checked in with him at times to ask if I had enacted the feelings as he wished. My thoughts were to give control and authorship to Joshua over his play activity, to clarify acts and their consequences and to serve as a check-in to prevent the play activity from becoming too overwhelming:

**Child**: Putting spiders in people's pockets. And then this is…then she finds out that he put spiders in people's pockets.
**Therapist**: How does she react?
**Child**: Really really really really really really really really mad.
**Therapist (as mother)**: Ah. OK. Son get over here right now! Like that?
**Child**: Yeah. Then he still doesn't do anything.
**Therapist** (as mother): Son, get over here now or you're grounded! Ah. Get! What should she do?

**Child**: Since he's outside in the yard with his girlfriend, she's going to come outside but he hides.
**Therapist**: Where is he? I think he's outside with his girlfriend. I need to find him. Where is he? I can't find him.

Sometimes expressive interventions took the form of clarification, in this instance by indirectly validating both Joshua's play reality and his experiential reality. In the first session, he "played" with the idea that different species could be a family. A Chinese dragon and a Tokyo dragon gave birth to a little dragon. But the members of the family all had different physical characteristics. In a confirmation of what constitutes a family, the therapist said, "You're family…you're different and you're family."

Other times, through expressive interventions, Joshua was able to recall feelings of past events and associate them with new understandings based on his current feelings. Several times, a character left its parents and the parents were "sad" and "mad" about the departure. This event in Joshua's play activity might have referred to several events from his past: for example, his brother's departure for the residential treatment center, or his own separation from his own biological parents years ago, or another as yet unrecalled separation from his past. Labels for feelings led to a deepening of understanding of past events and their multiple determinants that contributed to his play narratives.

Finally, other expressive interventions could have been used; for instance, interpretation of defenses. I chose not to interpret Joshua's defenses, however, partly because I felt that such interpretations might interrupt the flow of his play activity and his authorship over his story, essential elements in the treatment of PTSD.

The course of therapy adhered as closely as possible to the supportive and expressive principles discussed above.

# CHAPTER IV

## SUMMARY AND ANALYSIS OF SESSIONS

The following summaries of the sessions were coded using the CPTI-ATR (Chazan & Cohen, 2003). Three sessions were completed in front of a camera. Session #1 took place on 3/7/08; session #2 took place on 4/30/08; and session #3 took place on 6/19/08. Sessions were not evenly chronologically spaced because Joshua missed some sessions.

### Summary and Analysis of Session #1

Joshua began with a drawing on an etch-a-sketch-like board. He drew a picture of his therapist with some wild animals (a moose, a puma, a penguin and a narwhal whale). Then he told me that narwhals were like unicorns and that unicorns actually existed before Christ (B.C.).

When the play activity began, action centered on a family with pets, but the pets' appearances did not resemble their labels. For example, the pet cat was physically a dragon, and the pet fish was physically a crocodile. So the therapist as the son voiced confusion: the cat "doesn't really look like a cat." In response, Joshua said: "just because they're different, doesn't mean they're family."

Most families resemble one another. However Joshua's statement might reflect that he feels different from his grandmother and therefore does not consider her family.

Or Joshua might wonder how and why "familial" feelings arise with a stranger (his therapist).

The cat ("cat dragon") had the paws of a cat and the body of a dragon. This "cat dragon" was the offspring of his mother, a cat, and his father, a dragon. Attributes of these animals may have matched Joshua's own parents: aloof mother and a mythical father. His mother has been in and out of his life, and he is aware only of the myths or stories he has heard about his father, who has been in and out of jail. Joshua might have imagined what parts of me are from my mother and what parts of me are from my father.

He may have also wrestled with another question: How do I make sense of my differences with someone who acts like a parent but is not related to me? In the following play sequence, the "cat dragon" protected the boy from Godzilla, who lived deep in the forest and traveled with demons. Here, the same question is asked as Joshua compared Godzilla, a Tokyo dragon, with his traveling companion, a Chinese dragon. Joshua claimed that they were related and therefore a "family" because the Tokyo dragon (Godzilla) had a dragon body and the Chinese dragon (demon) had dragon qualities. It is possible that Joshua thought about how different beings can make a family and by extension how his therapist, an Asian American man, fits with him, an African American boy.

With the mention of a family, Joshua's thoughts drifted toward his brother, who currently lives in a residential treatment facility. The "cat dragon" announced to his owner that they could no longer live together because he ("cat dragon") wanted to be with the rest of his family (his brother). The boy asked whether or not his pet really wanted to leave. Joshua responded with a seemingly unrelated answer. Within the

statement, Joshua expressed ambivalence about leaving his family to live with his brother: "Did you know that Godzilla can actually walk fast even though it looks like he's walking slow because he has big feet?"

Unlike previous sessions when I first met Joshua, he allowed the characters in his play activity to have situation-appropriate feelings. The boy, played by me, was allowed to be "sad" when his pet left, and the parents were allowed to be sad and "mostly really mad" when their pet left. After identifying their feelings, the parents set out to find the "cat dragon" and to destroy Godzilla. In the battle Godzilla and the "cat dragon" breathed fire on the parents, and the mother was thrown across the room. When the "cat dragon" threatened to rip the father "from limb from limb," Joshua revealed that the "cat dragon" and his brother were angry at the parents for "interrupting" the family. It seemed that the play activity directly reflected Joshua's experiences and how he coped and managed separation from his brother. Angry feelings abated when the parents removed their threat of a forced separation:

**Therapist**: They can understand him? Who can understand him? Oh they can.
**Therapist** as father: No! Don't rip me from limb to limb! I need to get out of here.
**Child** as dragon: That will teach you a lesson from interrupting my family…my brother.
**Therapist** as father: You want to be with your brother?
**Child** as dragon: Yup. Not with you guys anymore
**Therapist** as father: Can't we see you sometime?
**Child** as dragon: Nope.
**Therapist** as father: Can't we visit with you?
**Child** as dragon: Nope.
**Therapist** as father: Well, we miss you.
**Child** as dragon: I understand.
**Therapist** as father: You really want to be with your brother, don't you?
**Child** as dragon: Yup, but I don't want you guys interfering with my brother and me.
**Therapist** as father: What if we agree that we won't take you away.
**Child** as dragon: Yes.

As the parents talked to their pet, the "cat dragon," they discovered that he was suspicious of being burned with torches by his parents. The dragon noted: "I have 20-20 eyesight and I can really see far away from you guys." This hypervigilant quality in "cat dragon" seemed like an adaptive response in life-threatening situations. Threat of harm prevented either character in the play activity from securely attaching to each other. The dragon feared torches and the father feared evisceration. At some point the "cat dragon" felt safe; he reunited with his father and licked the father's face to show affection. Joshua did not make any eye contact with the therapist as he voiced that the "cat dragon" loved the father.

Once the conflict between parents and pet was understood and resolved, an alliance between parents and pets followed. A once-frightening monster, Godzilla, became a "harmless" helpful creature who guided the parents through the dangerous forest filled with poison ivy. In the forest, the father sought to heal his wife from the injuries Godzilla caused with "pokeberries."

Imagery in the cure was sexual. Not only was the name intrusive and sexual, "poke" and "berry," but the mechanism of the pokeberry's healing evoked oral intercourse:

**Child** as Godzilla: It may taste horrible, just like bubble gum but then it flows to the belly and explodes.
**Therapist** as father: It may taste horrible and flows to the belly and explodes? Isn't it going to hurt her?
**Child** as Godzilla: No. This takes 20 minutes

After the Godzilla led the parents to a cure, adoption followed. The "cat dragon" fed his brother. Feeding occurred in the manner that a mother bird feeds a baby bird: he ate a piece of sushi, chewed it up and regurgitated it into his brother's mouth. Again, the

play activity suggested oral intercourse. Alternatively, this play activity could have suggested past experiences in which Joshua was force-fed oatmeal until he choked:

**Child**: Well everytime. Well he's still hungry…it's like because…if you're a dragon, you barf up your food and feed your brother.
**Therapist**: Oh you barf your food up and feed your brother?
**Child**: Yeah, like penguins do.
**Therapist** as Child: Oh am I feeding Godzie the wrong way then?
**Child**: Yeah.
**Therapist** as Child: He can't really eat what I'm putting up in his mouth right?
**Child**: Yeah, because you're putting the whole thing in his mouth and it kind of chokes him.
**Therapist** as Child: Godzie is really dependent on you, isn't he? How can he eat without you?
**Child** as dragon: If he doesn't eat without me, he won't survive.

The play activity also suggested a symbiotic relationship between two brothers.

Through adoption, Joshua worked through both the reasons for being rejected and the feelings of rejection. The parents adopted Godzilla in spite of his nature to be wild and messy. When the therapist questioned Godzilla about changing his destructive habits, Joshua made references to his own past experiences living away from his family: "I'm pretty professional because I used to live in someone's house." In the end the parents decided, with input from their son, to adopt Godzilla in spite of his omnipotence, wild nature, and messiness.

The session ended similarly to its beginning. Joshua moved all of the characters to the house and they went to sleep. The child lived in a large house with his parents and with many wild animals, except rather than draw animals, he placed them alongside the little boy and his parents.

Summary and Analysis of Session #2

Joshua created a battle scene in which a mother sat as if watching a sporting event. During the battle, she nearly got hit by a firearm: the boundaries between watching and participating blurred. Who offered protection from danger? A pint-sized character made out of lego blocks that Joshua named "little trooper" offered protection. The mother admired his strength despite being so small. He was attacked yet subdued larger foes.

Joshua mixed mythology and popular culture in his play activity. His hero, little trooper, gained strength after eating some "wild spinach," much as Popeye did when bullied by Bluto in the cartoon series. Obi Wan Kenobi trained little trooper. In the Star Wars trilogy, Obi Wan Kenobi was the mentor of Luke Skywalker, who defeated the Evil Emperor. Luke Skywalker succeeded where his father had failed. Rather than fall to the "dark side" as his father had, Luke prevailed and was not tempted by the prospect of omnipotence and evil.

The line between good and evil in Joshua's play activity was obscure. The storm troopers or little trooper represented the dark side. Yet little trooper was trained by the good Obi Wan Kenobi and was also synonymous with Obi Wan Kenobi.

Joshua has had struggles adhering to rules, and the epic characters he chose may describe his own struggles avoiding trouble at school. His battle between "good" and "evil" may also suggest the struggles of his brother, who was hospitalized for physically aggressive behaviors and placed in a residence. The struggle between good and evil might be more universal. In the session, he cautioned the mother: "But I warn you…not to underestimate the dark side."

Mentor story mirrored mentor story. Little trooper functioned both as a mentor and as an unattainable lover to the mother character. Throughout the play activity, both roles as mentor and lover mixed.

**Therapist** as mother: How did you do that little trooper?
**Child** as little trooper: It was easy. All you have to do is jump and put your fist down.
**Therapist** as mother: Do you think I can do that too? Jump and put my fist down.
**Child** as little trooper: No you have to do it hard, like this (demonstrates)
Something explodes.
**Therapist** as mother: What just happened?
**Child** as little trooper: It exploded. You try.
**Therapist** as mother: Jump up hard and…
**Child** as little trooper: She hurt her hand.
**Therapist** as mother: Ow my hand! Ow!
**Child** as little trooper: Maybe this kind of thing is not for you. (Flies off)
**Therapist** as mother: Gosh…will I ever be able to be strong like you?
**Child** as little trooper: She's in love with him.…with little trooper.
**Therapist**: Should she say that to him?
**Child**: Yes. He ran away.
**Therapist** as mother: Little trooper come back, I wanted to tell you something. Little trooper.
Makes little trooper fight someone.

When the mother pursued little trooper, he fled and took on a mentoring role. The play activity symbolized the blurring of boundaries in Joshua's own life with parents. Some of the adults in Joshua's past have not taken care of him and have left Joshua and his siblings to care for themselves or learn for themselves.

The little trooper, a name that connotes "soldiering on" or that one is a "good sport," taught everything he knew to the mother. He announced that she had "power that nobody else has" after he taught her self-defense. Uncertain of her own power, she questioned her other capabilities. Little trooper told her that she could fly, and that she had mind control ("you shoot out numbers like with your mind"). Once she no longer needed him for protection, he left with his criminal friend. In this scene, Joshua

continued a defensive/coping strategy of doing and undoing. First he helped the mother gain strength and not be seduced by the dark side, and then he himself proceeded to the dark side with the criminal. The activity in his play suggests some struggle with shifting alliances between good and bad.

After mentoring the mother, little trooper announced that he no longer loved her. She became angry and chased little trooper and the criminal. In this scene, little trooper punched his mother, tried to leave her and felt guilt about hurting her.

**Child** as little trooper: OK. Say, your mom and I were having a little fight and she loves me and I don't love her.
**Therapist** as son: You don't love her?
**Child** as little trooper: No, I love her, but she has some powers that I can't handle and so I started to punch her in the face and she started bleeding and now I'm healing her.
**Therapist** as son: Why did you punch my mommy in the face?
**Child** as little trooper: Because she was trying to chase me and I didn't like her chasing me because chasing me makes me nervous.
**Therapist** as mother: What just happened? The last thing I remember was I was chasing little trooper and he punched me in the face and made me bleed.
Hears breathing.
**Therapist** as mother: Oh, there's little trooper now. Little trooper, why did you punch me in the face? I loved you. Should I take your hat off? What should she do?
**Child**: Take his helmet off.
**Therapist** as mother: I'll take your helmet off. Gasps. Are you dying?
Breathing.

In a reference to the Star Wars Trilogy little trooper asked the mother to remove his helmet. In the Star Wars Trilogy scene, a battle between good and evil preceded Darth Vader's ("Dark Father") request for Luke Skywalker to remove his helmet. Luke Skywalker believed that his father still had a good side to him. He fought the Evil Emperor in the hope of saving his father, Darth Vader. Right before defeat by the Evil Emperor, Darth Vader had a change of heart and saved Luke Skywalker. Tired and

battle-worn, Darth Vader asked Luke Skywalker to remove his helmet and then he died after seeing his son.

In this play activity, the Oedipal conflict moved toward a resolution. Little trooper rejected the mother and discovered another aspect of himself. He saw a "charming" and "handsome" side to himself emerge from a cocoon.

**Therapist** as mother: Oh no, you split into 3 pieces. What's happening little trooper?
**Child** as little trooper: I'm dying.
**Therapist** as mother: And your body's going where? Into space?
**Child** as little trooper; It's not that I'm dying, it's just that I'm changing.
**Therapist** as mother: You're changing.
**Child** as little trooper; Like a butterfly. So now I'm becoming more handsome and charming.
**Therapist** as mother: You're becoming more handsome and charming.
**Child** as little trooper: Yes, and I'm becoming stronger, like nobody else is.
**Therapist** as mother: Stronger than me? Wow, he's handsome and charming. Breathing, gasping.
**Child**: He's in a cocoon.

Little trooper shed his dark side and he blossomed into a butterfly. His last statement to his therapist in the above sample of the play activity is defensive and protects him from the advances of his mother. Once out of the cocoon, little trooper rejected the mother and announced that he had a girlfriend. When she found out, the mother became sad and angry.

Summary and Analysis of Session #3

Session 3's story arc began with a battle between an evil side and a good side. It ended with an unresolved struggle between two brothers who are in love with the same girl. At the end of the session, one brother urinated on the other brother.

The good vs. evil theme Joshua continued from the previous session. As in the previous session, the characters could not commit to one side or the other. The two sides

were chosen much like classmates choose teams in elementary-school gym class. During the selection process, Joshua placed a father against his son and wife. This placement echoed earlier Oedipal themes of Session #2 with the placement of the son and mother against the father.

Once Joshua balanced the sides with equal numbers, he animated the good side. A member of the good side pursued and injured a baby and its mother. It seemed haphazard who was good and who was bad; bad people did good things and good people did bad things. Confusion or random assignment of who was good and who was bad may have emerged from his own history. It has been those "good" people in his life who mistreated him and those "bad" people who have nurtured him (sometimes the same person).

In the battle, Godzilla emerged as the main antagonist. He was very destructive and decimated both the good and bad sides with his tail. Godzilla's tail, a phallic symbol in Joshua's play activity, symbolized both power and weakness. With his tail Godzilla knocked over all combatants and shouted: "I shall rule!" Godzilla's tail was also the weakness through which he was later defeated. The tail also symbolized a penis and a possible suggestion of oral intercourse. In the following snippet, Godzilla flew above, a possible anxious reaction to the threat of castration or bodily harm.

**Therapist**: He's knocking over the bad guys too!
Dinosaur bites Godzilla on the tail.
**Child**: Ouch! That's his weakness.
**Therapist**: Oh, he found a weakness? (Therapist makes the dinosaur bite Godzilla on the tail and he repeatedly says, "ouch!")
**Therapist**: Guys I found his weakness. It's his tail!
Makes the others chase him.
**Therapist**: Let's get his tail!
**Child**: No! (flies up). I'm safe!

The anxiety provoked a defensive reaction. Godzilla first blew fire on the tiger. Then in a reference to the Star Wars trilogy, he announced that "electricity" was the tiger's weakness. (In the Star Wars trilogy, the Evil Emperor used electricity to shock Luke Skywalker.) With a blast of electricity, the tiger flew across the room. It seemed that too much power might have been threatening, so Joshua introduced water to protect the tiger against the electrical blasts. In this session, Joshua tempered his identification with the aggressor by giving the aggressor weaknesses and by giving the victims tools to heal.

Again, suggestive of oral intercourse, the tiger and others continued their torment of Godzilla and bit at his tail. The end of Godzilla's tail fell off (castration anxiety) and revealed a smaller stub that Joshua noted was Gozilla's "real weakness." The theme repeated. Godzilla's power intensified as did the tiger's power. The tiger got blasted with electricity, and he drank more water. The tiger and others bit Godzilla's tail, again suggestive of oral intercourse, and Godzilla revealed his real weakness and fled:

**Therapist**: I am going to be able to manage the electricity because I had enough water. (Godzilla chases him with electricity several times).
**Child**: He's almost out now.
**Therapist**: Oh oh! The next time I'm not going to be able to…(bites Godzilla's tail).
**Child**: That's another fake tail.
**Therapist**: Guy's help me. (Bites the tail). I'm eating his tail. I'm biting his tail.
**Child** (laughs): That tickles. That tickles. It tickles.
**Therapist**: (Picks up another bad guy). This guy's bad right? Is it only the good guys or the bad guys?
**Child**: The good guys are…the bad guys are attacking him because he knocked them down.
The bad guys jump on Godzilla's tail and he blasts off.
**Therapist**: Oh he got away!
**Child**: And then my weakness is my heart.
**Therapist**: Where is Godzilla's heart?
**Child**: I have two hearts. One is right over here (points to his tail).
**Therapist**: He's telling us all his secrets.
**Child**: Actually wait, this one is right over here (points lower to his tail).

**Therapist**: We bit that!
**Child**: Yeah, but it still hurts. And this one is the really really one that really hurts. (points to his chest area).

This second theme repetition differed from the first in several respects. First, Joshua noted that the biting of Godzilla's tail "tickles." Here he added another feeling sensation to the suggestion of oral intercourse. Joshua also added a vulnerable body part; in addition to the tail, Godzilla's heart was also a weakness. As he discussed the vulnerability he became slightly cognitively disoriented so that his syntax was affected: "And this one is the really really one really hurts."

Joshua shifted and found another strategy for the good guys to use. They made a plan to put Godzilla to sleep with potion. Joshua placed on character in a "one-down" (castrated) position: "…even though I'm not the smart one, you are, but I have a good plan, right?" The one-down character organized the plan that ultimately worked. The plan was based on the idea of cleverness to combat or neutralize physical strength. The character stated: "Even though you guys used to bully me and tell me that I'm weird, I came up with a great plan."

The story shifted abruptly again with another dream-like transformation. Godzilla was not Godzilla (just as the tail was not the real vulnerability), but "Freddy Markel Cartlin." Mr. Cartlin was the science teacher who gave one brother an "F" in science and the other, "smarter" brother an "A." Joshua has always excelled at Science and was, even in pre-school, praised by his teachers for his advanced scientific knowledge. It is possible that this polar distinction between the brothers symbolized Joshua (the A student) and his brother, who resides in a residential treatment facility (F student).

If this interpretation about the two brothers is correct, the following sequence described the brother's relationship. Joshua compared one brother, who knew how much power to use, with the other brother, who got out of control. Even though the "smart brother" got an A, he had difficulty judging how much power to use. As a result of the poor judgment, Joshua provided rewards for the brother who maintained control. The brother who managed his behavior better earned four scoops of ice cream. The brother who did not lost television privileges. Throughout this play activity, Joshua also equated being smart and maintaining one's behavior with getting the "hotties."

The session ended with a struggle between the mother who attempted to set limits with the son who misbehaved. The mother set limits around the son having a girlfriend and sleeping with her. Here, the son straddled both an age group in which parents spanked their children with an age group in which dating and interest in sexual relationships persisted. A triad between the two brothers and one of their girlfriends developed after the mother was sent to prison for hitting her son for loving his girlfriend. Joshua ended the session with one brother's protests about the other who peed on him. Then he said, "To be continued."

# CHAPTER V

## EMPIRICAL FINDINGS

Child Behavior Checklist (Teacher Report Form)

Figure 5.1 represents changes in ratings from the inception of this study to three months later for the Child Behavior Checklist (CBCL) as completed by Joshua's teacher.

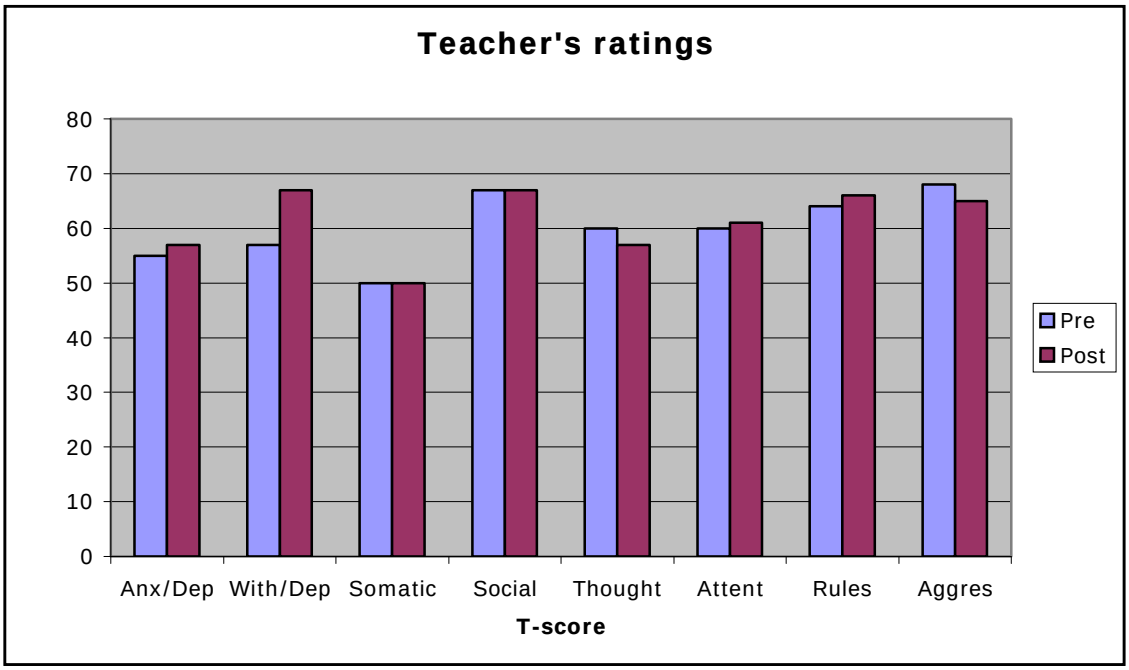


Figure 5.1 Teacher's Ratings (CBCL).

The teacher noticed minimal differences in ratings pre-study vs. three months later in all of the scales except for the withdrawn and depressed scale. She also rated Joshua as slightly more depressed and anxious following three months of treatment. The teacher rated Joshua as less aggressive three months later, but with more rule-breaking behaviors. Aggressive behaviors and social problems were the two behaviors that were borderline

clinically significant prior to the start of the research intervention. These scales remained in the borderline range for clinical significance and two others reached the borderline clinically significant range: Rule-breaking behavior and Withdrawn/Depressed behavior.

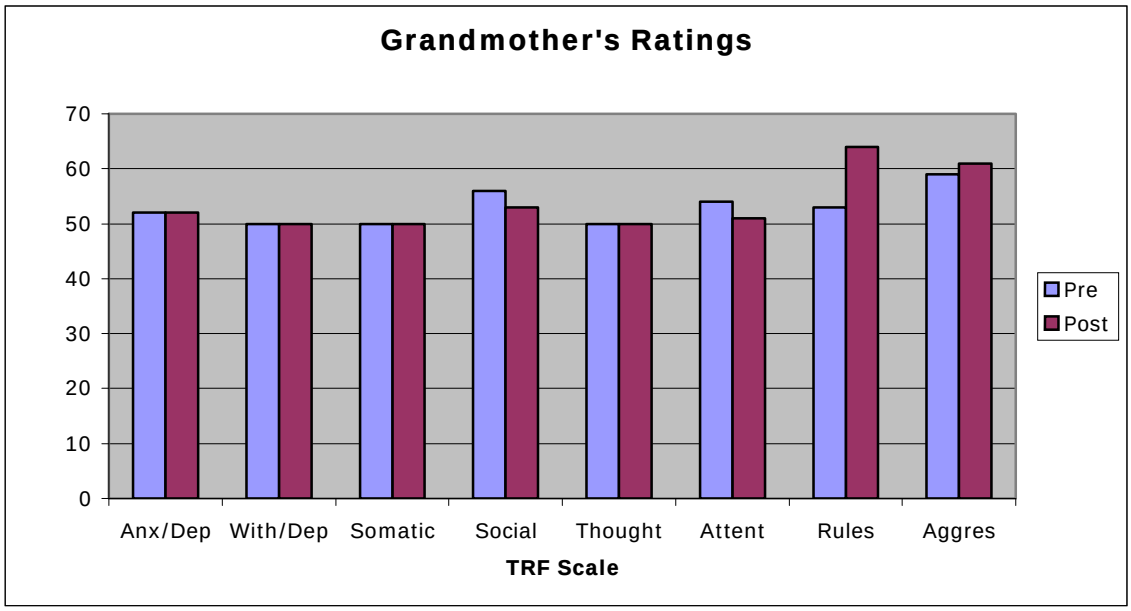


Figure 5.2 Grandmother's Ratings (CBCL).

Joshua's grandmother also rated his behavior before the study began and three months later. Figure 5.2 represents the changes in her ratings. The grandmother's ratings generally concurred with the teacher's ratings in the frequency that Joshua broke rules. However, she reported a higher level of aggression and did not endorse raised levels of anxiety or depression. She also reported a lower level of social and attention problems after three months of the study.

Results—Self-Perception Profile for Children (SPPC)

Figure 5.3 represents pre-study measures and measures three months later of Joshua's self-esteem as rated by Joshua, his teacher and his grandmother.

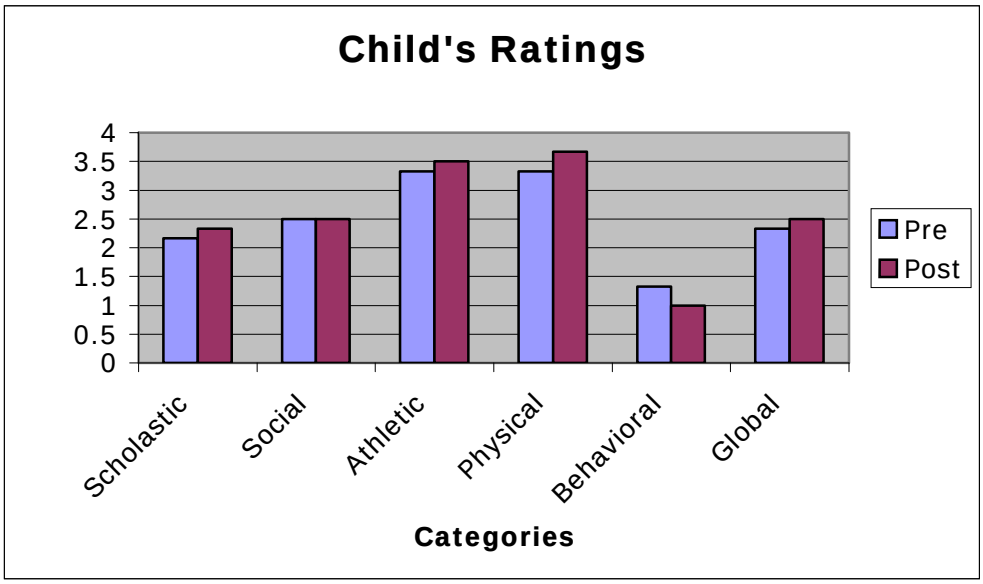


Figure 5.3 Child's Ratings (SPPC)

With the exception of the behavioral conduct category, Joshua reported that his self-esteem rose or stayed the same in all categories post-treatment.

Both Joshua and his third-grade teacher reported a higher scholastic self-esteem. She concurred with Joshua's perception of a lower behavioral conduct rating. His teacher reported that other self-esteem measures except for the athletic self-esteem (which she ranked lower) were unchanged. These differences are reflected in Figure 5.4 below.

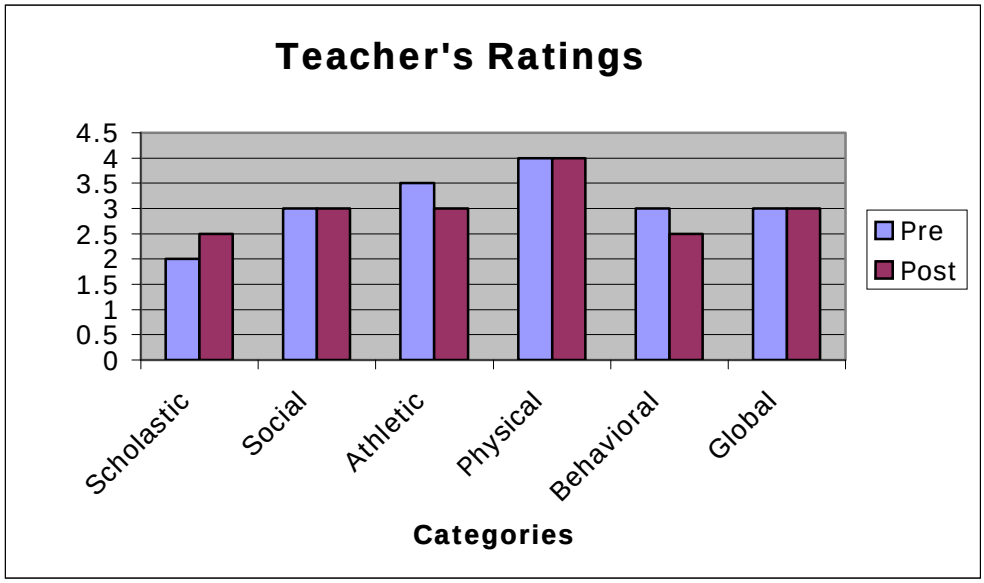


Figure 5.4 Teacher's Ratings (SPPC).

Joshua's grandmother reported lower post-study self-esteem across all self-esteem categories except for physical self-esteem. She concurred with Joshua and his teachers in lower self-esteem ratings in the Athletic and Behavioral categories. She rated lower self-esteem post-study in areas in which Joshua and his teacher reported an increase or the same rating: Scholastic, Social and Global. These differences are reflected in Figure 5.5 below.

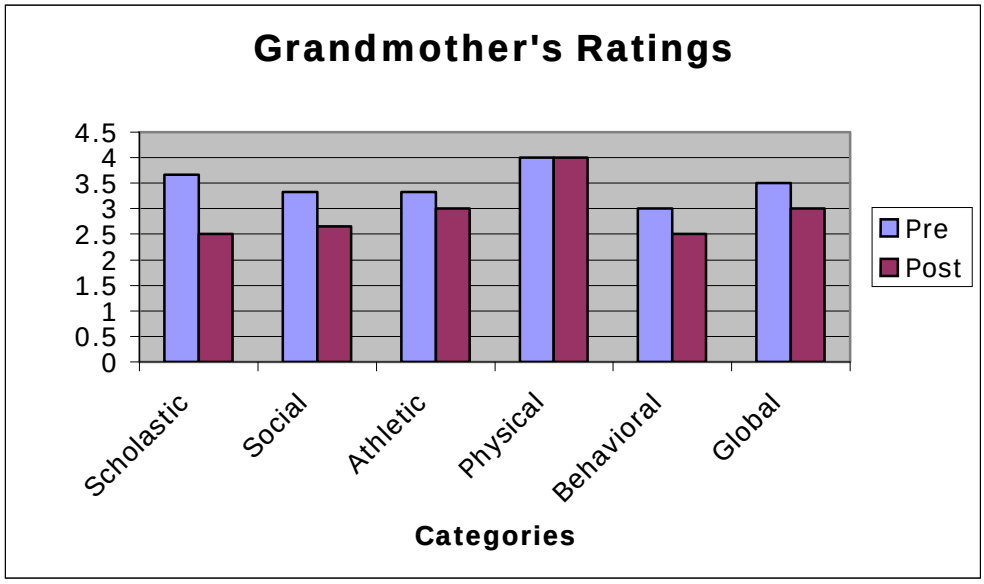


Figure 5.5 Grandmother's Ratings (SPPC).

Results-Child Play Therapy Instrument-Adaptation for Trauma Research (CPTI-ATR)

Descriptive Analysis of the Play Activity

Figure 5.6 CPTI-ATR Activity and Affect.

I found considerable evidence for Joshua's active participation in the first play session as depicted in Figure 5.6.

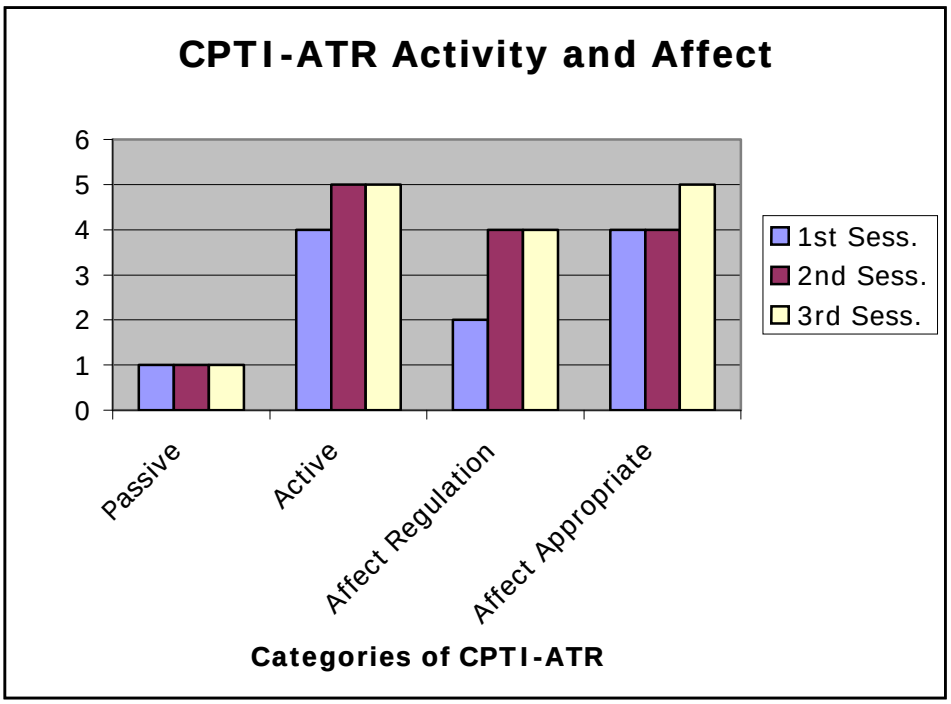


Figure 5.6 CPTI-ATR Activity and Affect.

In the second two sessions, active play was again most characteristic. Joshua consistently directed the play. Even when the content was strange, Joshua still provided direction:

**Child**: You play these guys (points to the people) and I'll play the animals.
**Therapist**: You want me to play the family and you'll play the animals?
**Child**: Uh huh.
**Therapist** as boy: Mom, I can't remember which one is the cat and which one is the fish. (Holds the little boy)
**Therapist** as the mother: I think this one is the cat (points to the dragon) and this one is the fish (point to the crocodile).
**Child**: Makes the triceratops pant like a dog.
**Therapist** as the boy: And that's our dog, right?
**Child**: Makes the dragon meow
**Therapist**: This is so confusing. Our cat really doesn't look like a cat.

Joshua was generally calm during his sessions and at times appeared anxious or over-stimulated. At times it appeared that Joshua enjoyed playing and at other times his emotions were difficult to read. He did not appear emotionally constricted in any of the

sessions; however he may have felt more anxious about the filming during the first session. By the end of the study, he expressed some disappointment that the filming was over. He was able to distance himself enough from the content to label the affect of the characters in his play activity with the following emotions: scared, angry, really really angry, and sad. He seemed engaged with me and appeared to have positive feelings toward me. He maintained eye contact with me intermittently throughout the session and he was aware of the camera even while engrossed in his play activity. At times Joshua turned his back to both the camera and to me. Joshua was also able to remove himself from the play activity altogether when needed. Several times throughout the sessions, he either told me to make sure that the camera was capturing the scene or he mentioned me by name to direct me. Mention of my name either followed upsetting content or it marked the intrusion of reality into Joshua's play activity:

**Child**: Let's go kill the other guys.
**Therapist**: Ok. Do you have a plan brother? You came up with such a good plan to knock down Godzilla and kill Godzilla.
**Child**: Scott he's not even the real Godzilla. He's not even the real Godzilla. I know who really is.
**Therapist**: Who is he?
**Child**: Freddy Markel Cartlin.
**Therapist**: Freddy Markel Cartlin?
**Child**: Yeah, he was our science teacher, remember?

Cognitive and Dynamic Components of the Play Activity Segment

Voluntary transformations of play objects occurred in all of the sessions. These changes are depicted in Figures 5.7 and 5.8.

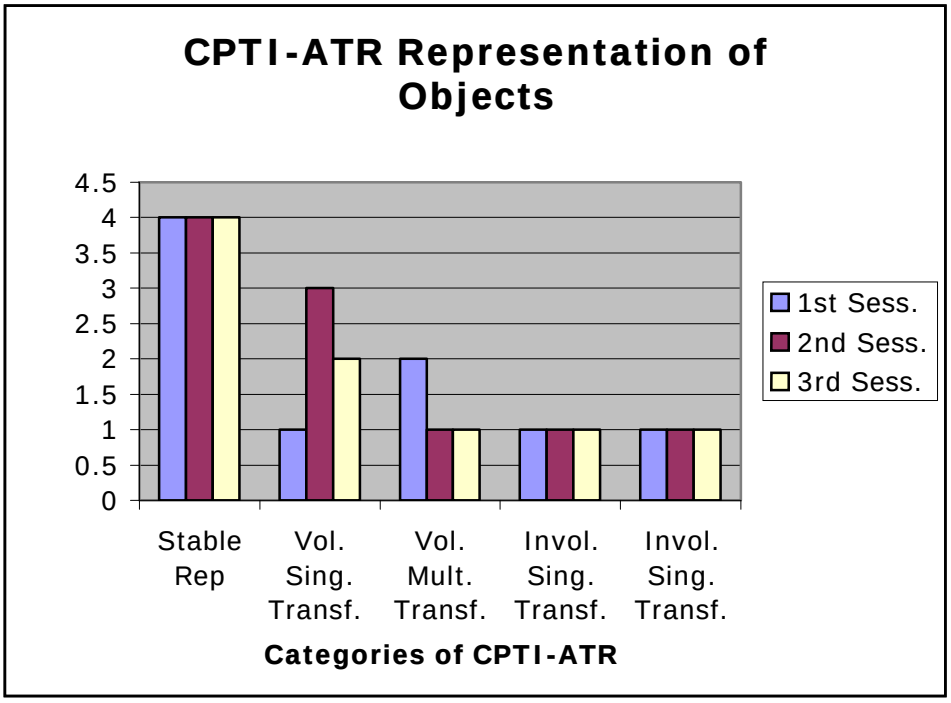


Figure 5.7 CPTI-ATR Representation of Objects.

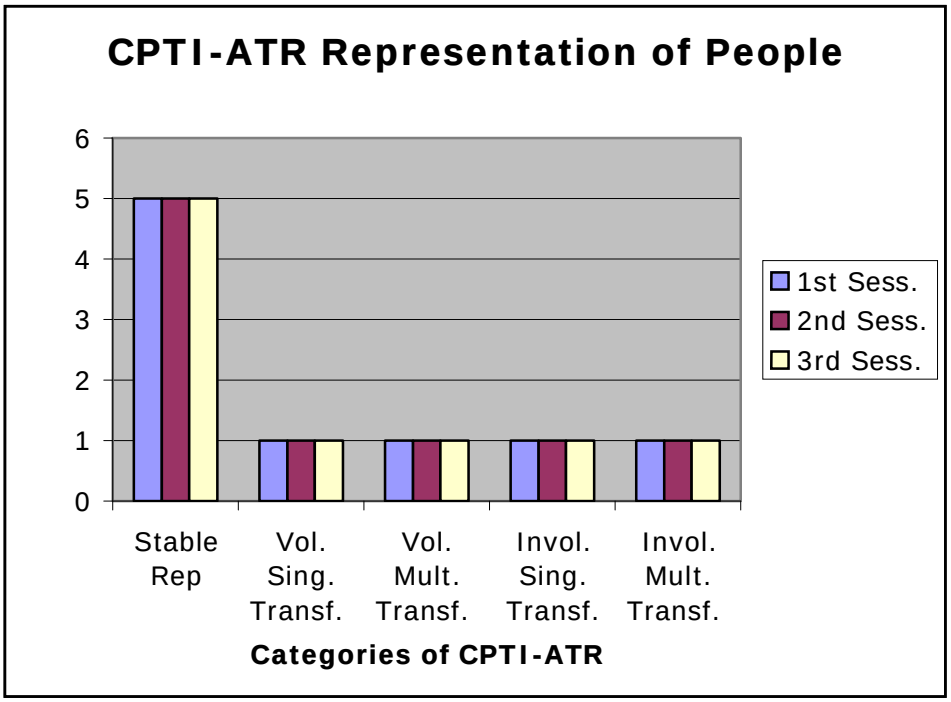


Figure 5.8 CPTI-Representation of People.

A mother turned into a dragon, a cat was represented by a dragon, an animal's tail died, characters switched from bad to good and good to bad, and a character blossomed like a butterfly:

**Child** as little trooper; It's not that I'm dying, it's just that I'm changing.
**Therapist** as mother: You're changing.
**Child** as little trooper; Like a butterfly. So now I'm becoming more handsome and charming.
**Therapist** as mother: You're becoming more handsome and charming.
**Child** as little trooper: Yes, and I'm becoming stronger, like nobody else is.
**Therapist** as mother: Stronger than me? Wow, he's handsome and charming. Breathing, gasping.
**Child**: He's in a cocoon.
**Therapist**: He's in a cocoon. We have about 5 minutes.
**Child**: So she can't actually see him.
**Therapist** as mother: He's in a cocoon. Oh. Is he coming out?

In this portion of the second session, Joshua was preoccupied with Oedipal themes. Here he blossomed into a more handsome and charming man and later announced that he had a girlfriend and was not available to the mother figure.

Table 5.1
Ratings of CPTI-ATR Variables in Each Session

| Variables | Session 1 | Session 2 | Session 3 |
|---|---|---|---|
| Activity vs. Passivity | 4 | 5 | 5 |
| Affect Regulation | 2 | 4 | 4 |
| Appropriate Affect | 4 | 4 | 5 |

A binomial distribution sign test revealed that the ratings of Joshua's activity in the session, his ability to regulate his affect and ability to have appropriate affect, changed together. The binomial distribution sign test revealed that the probability of

finding 8 of 9 ratings in the "4" or "5" range than would be expected was significant at the .01858 level. This finding indicates that the ratings from the CPTI-ATR all change together and show Joshua's expanding control over his own material in session.

Developmental Components of the Play Activity

Throughout Joshua's play activity psycho-sexual phases were represented symbolically. The predominance of each phase is represented in Figure 5.9.

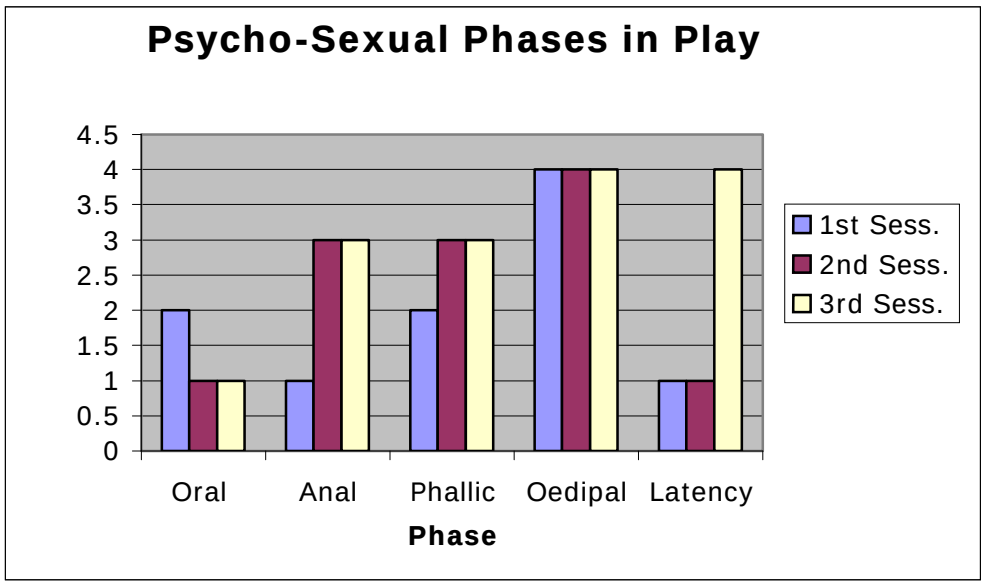


Figure 5.9 Psychosexual Phases in Play.

The oral phase was represented in the play when characters fed each other. In the first session (3/7/08) one character fed another some sushi. Minimal evidence for themes of the oral phase were represented in the play activity in the middle and last sessions.

Considerable evidence for themes of the anal phase arose in the second and third session of Joshua's play sessions. He constructed battle scenes and mentioned ripping characters from limb to limb. He also categorized animal figurines into good and bad before setting up a battle. He also played out a sadistic spanking scene between a mother and her son.

Joshua's play sessions were peppered with phallic phase themes that centered around the discharge of weapons in the battle scenes. Joshua also exhibited his physical abilities in the first session in which he proclaimed that nobody else could walk on his knees as he did. With some ambivalence, the character in his third session (6/19/08) hid his developing beauty and charisma while in a cocoon.

Joshua worked out and "played with" intergenerational triads and dealt with his Oedipal conflict (discussed above) in the second session (4/30/08). In this session, he spent much energy and time working out a relationship between a "little trooper" and a mother character. He also arranged fathers so that they directly opposed sons and mothers on a battle field in the third session (6/19/08).

Finally, Joshua played out latency phase components in his third session (6/19/08), in which he focused on rules, societal fairness, and morality. A mother disciplined a son too roughly and was sent to jail. A mother set limits with her son for his inability to manage his own behavior.

Table 5.2
Average Ratings of Psychosexual Phase in Play Activity

| Psycho-sexual Phase summaries | Session I | Session II | Session III |
|---|---|---|---|
| Average of ratings (Oral + Anal + Phallic) | 1.67 | 233 | 2.33 |
| Average of ratings (Oedipal + Latency) | 2.5 | 2.5 | 4 |

The binomial distribution sign test revealed that the probability of finding 3 out of 3 ratings higher in the Oedipal and Latency phases than the Oral, Anal, and Phallic phases than would be expected was not significant at the .125 level. The averages are depicted in the above Table 5.2. While not statistically significant, Joshua's focus in his play activity showed progression over treatment towards significant increase on Oedipal and Latency phases.

Functional Analysis of the Traumatic Play Activity

A functional analysis of the traumatic play activity showed that Joshua used a predominance of Cluster One Coping/Defensive Strategies: Re-Enactment with Soothing. The defensive strategies observed in the sessions included: Problem-Solving, Humor, Suppression, Sublimation, and Affiliation. This analysis is depicted in Figure 5.10 below.

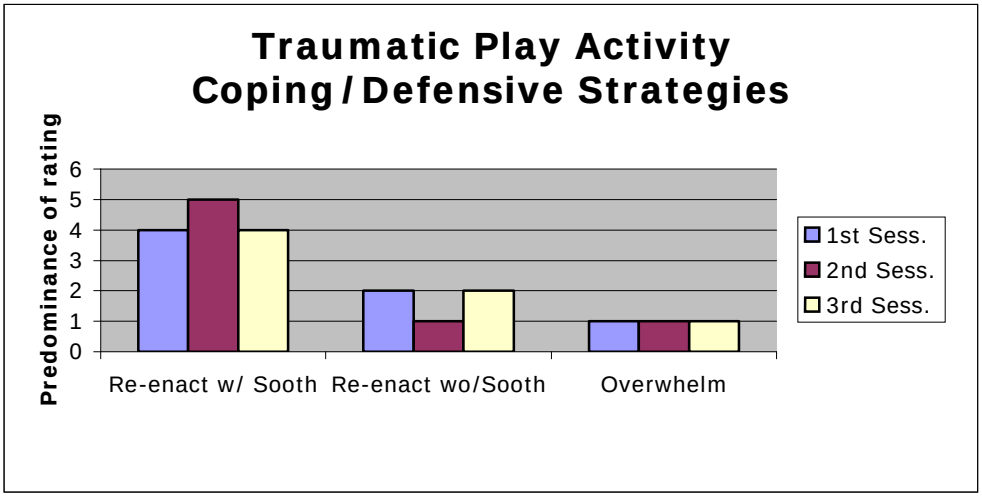


Figure 5.10 Traumatic Play Activity Coping/Defensive Strategies.

Only in the first and third session did Joshua's play activity rate in Cluster Two Coping/Defensive Strategies: Re-enactment without Soothing. The defensive strategies observed in sessions included: Doing and Undoing, Projection, Repression, and Avoidance.

Table 5.3
Average Ratings of Defense/Coping Strategies in Play Activity

| Traumatic Play Strategies Summaries | Session I | Session II | Session III |
|---|---|---|---|
| Cluster I | 4 | 5 | 4 |
| Cluster II/III Average | 1.5 | 1 | 1.5 |

The binomial distribution sign test revealed that the probability of finding 3 of 3 ratings in the "Re-Enactment With Soothing Category" than expected was not significant at the .125 level. In all three sessions, Joshua used coping/defensive strategies that fell

into the Cluster One: Re-Enactment with Soothing. These findings, while not statistically significant, indicate that Joshua consistently used coping/defensive strategies from Cluster One: Re-Enactment with Soothing over a three-month period.

When Joshua's play activity fell into Cluster One: Re-Enactment With Soothing, he was able to create story arcs with endings that did not end catastrophically. His affect was generally happy and he used humor in creating the dialogue of his characters. Characters solved problems, and they anticipated pitfalls to plans. This type of play activity predominated in the sessions.

Cluster Two: Re-Enactment Without Soothing in play activity created anxiety for me. Characters suddenly had power, or unpredictably shifted from good to evil. This unpredictable change may have occurred to frighten me. Characters flew up into space. Sadistic scenes went on beyond my own tolerance seemingly without end. At times the play activity included aggressive content.

Cluster Three: Overwhelming Re-Enactment ratings were generally low in all three sessions. It is possible that Joshua did not re-enact traumatic events that became overwhelming because he felt safety in the therapeutic setting. Joshua has had four years to become comfortable at St. Luke's-Roosevelt Hospital Center and has had only two therapists. He demonstrated that he felt safe enough to "play out" both meaningless and chaotic material while maintaining a sense of himself, his story, and his feelings.

Two months after the study was complete, Joshua continued to make progress in school and in getting along with his peers and family members. For a two-week period, he had a fantasy of running away to be with his brother. During that time period, he became more oppositional and disobeyed his older sister's orders. He also refused any

type of positive reinforcement from his aunt and grandmother. His wish to run away probably reflected his identification with the aggressor. In addition, these changes could have reflected a shift in his internalization of bad objects. After a family meeting, he changed his mind about living with his brother and made the decision to focus on getting along with his grandmother and sister. Two months after the family meeting (one month after the study ended) he made a new friend at school, and obeyed his sister and grandmother more consistently. This shift probably reflected an acceptance of "rules." He has become increasingly interested in talking in therapy sessions as well as in playing within the microsphere. Joshua's school interests have continued, and he has thrived in his science classes. He shares his Spanish vocabulary occasionally with his therapist during sessions. Themes of social interactions have emerged in his play activity mostly in the form of role playing how to approach friendship and rejection. His behavior and adherence to rules has improved both in school and at home according to reports from his grandmother.

# CHAPTER VI

## DISCUSSION OF CLINICAL AND RESEARCH FINDINGS

This study employed the use of the CPTI-ATR to assess Joshua's play activity in three sessions of a supportive and expressive psychodynamically-informed child treatment. The study utilized other instruments to document the change in self-esteem (SPPC) and in internalizing/externalizing behaviors (CBCL-TRF) of the child (Joshua) post-study.

Statistical limitations of the study are clear. Given the case study format, the results are not generalizable. However, the study used a model for documenting change and using assessment tools to provide a direction for supportive and expressive psychodynamically-informed child treatment. This study also laid groundwork, along with other published case studies and case reports, for the use of supportive and expressive psychodynamically-informed treatment for children diagnosed with PTSD.

The results in terms of measurable clinical progress were mixed. Joshua's self-esteem levels "improved" in several areas as predicted by hypothesis (2). However, his raised self-esteem ratings did not have an impact on his internalizing and externalizing behaviors. It was also not possible to determine with confidence whether the adaptive play measured by the CPTI-ATR led to Joshua's raised self-esteem and his more frequent behavior problems. However, the trends found in Joshua's play activity indicated that the supportive and expressive psychotherapeutic interventions proceeded in a positive

direction. He did not regress in his play activity, and his play was progressively adaptive and provided soothing. His concept of self remained stable throughout the treatment.

What explains the raised level of withdrawn/depressed symptoms and rule-breaking behaviors noted by Joshua's teacher and his grandmother in the CBCL? Several possibilities exist.

The treatment may not have been effective in reducing Joshua's withdrawn/depressed symptomatology or associated externalizing behaviors. It is also possible that Joshua's level of withdrawn and depressed symptomatology was not significantly affected in either direction by the treatment. In other words, Joshua's levels of withdrawn or depressed behaviors might naturally go up and down in spite of treatment.

Other reasons for the mixed result have to do with the teacher and grandparent's biases in their reports. For example, his teacher was forewarned about his behavior before he was transferred to her class. She was aware of his history of behavior problems that included physically striking one teacher and throwing a desk and chair in the classroom. His grandmother worried that Joshua might turn out to be like her daughter (his mother), who had difficulty regulating her affect and managing her behavior. These biases may have caused both respondents to skew reports of his behavior problems. In his grandmother's case, she continued to report difficulties in order to continue to receive help. However, for both respondents, Joshua's misbehaviors may have stood out more than his compliance with rules because of their set expectations of him.

Heightened reports of disruptive behavior may have been skewed by Joshua's efforts and frustration with peers. Over the period of treatment, Joshua struggled to make

friends and reported that he was bullied and provoked by peers. This corresponds with the teacher's report that Joshua had consistent difficulties in social areas at school. Trouble managing bullies or fielding provocative comments may have led to more aggressive outbursts or rule-breaking behaviors. Joshua quickly learned that consequences to misbehaviors included a reprieve from the classroom, away from the bullies.

The data from the CPTI-ATR suggests a different view of "progress" in the supportive and expressive psychodynamically-informed treatment. The findings from this study support the work from a previous empirical study (Cohen & Chazan, 2006) of children exposed to terror events. In that study, Cohen and Chazan (2006) discussed the utility of Cluster One: Re-Enactment With Soothing play activity in children recovering from trauma. They write:

> The evidence from this study, demonstrating the ability of young victims of terror to process traumatic events, using their powers of imagination, narrative-creation and soothing, is an important contribution to acknowledging children's natural resilience and the curative function of spontaneous play. (p. 23)

With use of defensive/coping strategies that fell in Cluster One: Re-Enactment With Soothing, Joshua rated consistently in the Oedipal and Latency phases of development rather than the Anal, Oral and Phallic phases of development.

At least two factors contributed to his consistent use of coping/defensive strategies that provided soothing. These factors are: (1) Joshua's strengths and (2) his relational context that included his grandmother and me, his therapist.

Joshua's intellect and creativity allowed him to make use of symbolic play activity in a constructive way. An individual must be able to use symbols or "masked

symbols" (Sarnoff, 1976) in order to progress from the Oedipal phase to Latency. From the beginning of treatment four years ago, Joshua gravitated toward toys and made use of them in creating scenarios that mirrored his past life and present concerns. It was also apparent that he was a keen observer of his surrounding, and he acquired and used a rich vocabulary during his therapy sessions.

Joshua's relationship with his grandmother and therapist differed markedly from his relationship with his biological parents. At times his grandmother spoke fondly of her grandson and actively sought out opportunities for his intellectual and social growth. While she was sometimes overly punitive with him, she consistently provided material supplies for him and quickly addressed any problems in his life. She was never physically abusive. Joshua's therapist functioned in some ways as a surrogate parent. He attended school meetings when Joshua had hurt other children in school. Birthdays were routinely celebrated with a small cake and presents during sessions.

Joshua's grandmother also shared significant personal history with his therapist. Most of what she shared related specifically to both her difficulties parenting him and her wishes for him. She noted that she had been physically abused as a child and was saved by an uncle and aunt who moved her away from her toxic environment to the country. Here she thrived and won a scholarship to attend college. Sometimes her relationship with Joshua's therapist mimicked a co-parenting relationship. At other times, she spoke personally about her own aspirations and troubles. She strove to pursue a career in teaching children or a career in law.

Joshua expressed some ambivalence about living with his grandmother. On the one hand, he wished to be like other children in school who were raised by their own

mothers and fathers. When he visited with his own mother or spoke to her on the phone, these wishes and fantasies grew. On the other hand, Joshua also spoke openly about how he loved his grandmother and didn't want to leave her. His attachment with his grandmother was most threatened when she could not handle his anger, and he sometimes threatened to run away from her. Faced with this rejection, his grandmother threatened to place him in foster care. This misunderstanding led to tension between Joshua and his grandmother, but she managed to communicate that she still wanted to parent him.

The therapist and Joshua maintained a relationship within traditional psychotherapeutic boundaries. Joshua tested the therapist about extending the psychotherapy hour, but requests were never granted. Joshua also asked to borrow toys from the therapist's office. This arrangement was agreed upon under strict conditions: (1) Joshua return the toy the following week, (2) if Joshua did not return the toy, he would not be able to borrow toys from the therapist's office. Joshua was connected to the therapist, and several times throughout treatment, Joshua wished for physical contact. Again these requests were not granted and instead other gestures of connection were agreed upon like hand shakes.

It is arguable that having a configuration of care that included a male therapist and his grandmother was a "ballast" for Joshua to use Cluster One: Re-Enactment with Soothing coping/defensive strategies in his play activity. This configuration of care allowed for the use of more adaptive defensive/coping strategies on a consistent basis. It may have also allowed Joshua to begin to resolve traumatic oedipal conflicts and to progress to latency.

Joshua's original parental configuration included two "toxic" adults who did not adequately care for him. Under the care of these parents, his development arrested because of exposure to toxic, chronic trauma. He was "stuck" in a repetitive, traumatic experience.

Through her experience as a child, Joshua's grandmother was given a "message" by her aunt and uncle that she had potential. As a result, she enabled Joshua to conceptualize the world differently by being there for him and by finding him psycho-therapeutic treatment. Her "message" to him, as to herself as a child, was that he could get better and master the traumatic experiences.

This supportive-expressive psychodynamically-informed therapy did not focus on interpretation as much as it focused on helping Joshua find closure to give him distance from the traumatic events. In the second and third sessions of the study, Joshua's focus shifted from oedipal concerns to latency concerns. The character "little trooper" in the second session announced that he did not love the mother figure anymore. Then he was transformed from a "butterfly" to a more handsome and charming figure. Mental energy was freed to cathect to other objects. The self represented in Joshua's play activity accepted the generational boundaries and was open to the possibility that others could be attracted to him.

During the period of latency, a new array of coping/defensive strategies are employed to manage sexual and aggressive drives. According to Sarnoff (1976) defensive strategies include: reaction formation, obsessional defensive activities, repression, symbolization and sublimation. Since beginning treatment with the therapist,

Joshua had the cognitive capacity for symbol formation. This capacity allowed him to create what Sarnoff refers to as the "structure of latency:"

> Through this special organization of the ego, the child quells the humiliation of trauma and demonstrated impotence through dismantling the memories of the traumatic event or seduction, and actively reorganizes and synthesizes them into highly symbolized and displaced stories. Through these, a latency child can discharge drives without resorting to anal-sadistic drive organization. He gains comfort or revenge without threatening the situation in which he wishes to function well (e.g., school), or interfering with his emotional equilibrium or adjustment. The mechanisms involved actively produce fantasies and symbols to be used for discharge, in which the hero can be covertly identified with the child's own self. (p. 154)

The "hero" of Joshua's play activity outsmarted a frightening monster, became interested in attracting girls from school, and was able to figure out how much power to use in subduing an enemy without overdoing it.

According to Sarnoff (1976), the transition to the latency phase ushers in cognitive changes as well as a different array of defensive/coping strategies. One change involves the ability to differentiate fantasy from reality. Fantasy events are portrayed and seen from an "as if" viewpoint. The superego also plays a more prominent role in motivating affects. Specifically, children in the latency stage feel guilt and use this feeling in their ethical decision-making. Finally, sexual and aggressive drives are suppressed, and children become calm and focused on learning. Both Joshua and his teacher reported a higher scholastic self-esteem post-study.

Evidence of the development of Latency defensive/coping strategies in the sessions include repressed sexual activity, symbolization of the father and son

rivalry in a battle, symbolization of the therapeutic relationship in a mentorship between a warrior and his protégé.

The use of the CPTI-ATR provided evidence that therapeutic and developmental progress cannot always be measured by changes in symptomatology. The psychosexual phase scale of the CPTI-ATR gave a focus for detecting developmental change over a series of sessions.

More difficult to reconcile are the reports of depression by Joshua's teacher and his grandmother. Mentalization theories of Fonagy, Gergely, Jurist and Target (2004) offer a possible explanation. If, through play therapy, children are afforded an opportunity to integrate and mentalize (to understand the mental state of oneself and others), they can begin to consolidate a continuous self. They write:

> …The child can fit his thinking to the world without feeling as though he has to change himself in order to change his mind…It allows for a distinction between inner and outer truth, enabling the child to understand that the fact that someone is behaving in a particular way does not mean that things are like that. While this may not be important in all contexts, we believe that it becomes critical in cases of maltreatment or trauma, allowing the child to survive psychologically and relieving the pressure to relive the experience in concrete ways. (p. 264)

Further, they note if a therapist can help a child bridge reality and play activity by (1) accepting a child's mental state and feelings and (2) reflecting these mental states back to the child in a playful manner, then the child can have a basis for organizing and comparing numerous experiences. The play activity allowed Joshua to experience "important" figures in his life and to refashion the emotional distance between his fantasy of them and his experience of them in the everyday world. If this is the case, having a

basis for comparing numerous experiences and ingesting these experiences may contribute to deepening grief and mourning rather than alleviate it. Based upon Joshua's use of defenses and strategies used in the play activity (Cluster One: Re-Enactment With Soothing), we might expect this to be true. Furthermore, it is evidence of progress to be able to face reality without a reliance upon coping strategies and defenses that do not allow for resolution of conflict and the formation of secure attachments to others.

In a time in which clinicians are asked to treat symptoms, it has not always been clear that short-term evidence-based treatments effectively get to the roots of problems. This study, based upon a conceptual model of PTSD in which the impact of a traumatic event on a child's behaviors, thoughts, and emotions are a result of changes in his/her coping/defensive strategies, symptom alleviation is only one sign of progress. Other signs of progress, as documented by the CPTI-ATR, show that the increased use of adaptive play, the lessened use of primitive coping/defensive strategies, and lessened evidence of regression within sessions, are linked with progressive changes in a child's ego functioning as he recovers from past trauma.

# CHAPTER VII

## SUMMARY

Changes in symptomatology and in play activity were documented in a child diagnosed with PTSD over the course of three taped sessions. Specifically measures were taken using the CBCL TRF and the SPPC. Play activity was rated using the CPTI-ATR.

Categories of the CPTI-ATR were used to describe the progress made in sessions with Joshua, a nine year-old African American child diagnosed with PTSD. The following categories from the instrument were selected to study Joshua's play activity on an interval of every fourth session for three total sessions: child's activity vs. passivity in session, affect regulation in session, use of appropriate affect in session, representation of people and objects in session, psychosexual phases of development in session, and traumatic play strategies used in session. Throughout the process of analysis, I was afforded the luxury of scrutinizing Joshua's play activity and giving thought to the goals of treatment.

At the close of the study, Joshua's results were mixed. His depressive features and anxiety rose along with his self-esteem. In addition, his use of adaptive play activity increased significantly as he utilized coping/defensive strategies that allowed his play activity to provide soothing and comfort.

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# APPENDIX A

**CHILDREN'S PLAY THERAPY INSTRUMENT-ADAPTATION FOR**

**TRAUMA RESEARCH**

## Older Children
## (CPTI-ATR-4)

## RATING BOOKLET

## 8/31/08

**SEGMENTATION OF CHILD'S ACTIVITY**

| Segment # | Time (Screen Clock) | Markers (Write words or activities) | Category |
|---|---|---|---|
| _____ | Begin_____ | _____ | |
| | | _____ | |
| | End_____ | _____ | |
| | | _____ | |
| _____ | Begin_____ | _____ | |
| | | _____ | |
| | End_____ | _____ | |
| | | _____ | |
| _____ | Begin_____ | _____ | |
| | | _____ | |
| | End_____ | _____ | |
| | | _____ | |
| _____ | Begin_____ | _____ | |
| | | _____ | |
| | End_____ | _____ | |
| | | _____ | |
| _____ | Begin_____ | _____ | |
| | | _____ | |
| | End_____ | _____ | |

**********
**

_____ **Begin**_____ _____

_____

**End**_____ _____

_____

---

**COMMENTS ABOUT THE PLAY ACTIVITY SEGMENT CHOSEN FOR ANALYSIS**

**(# of Play Activity Segment_____)**

---

***DESCRIPTIVE ANALYSIS OF PLAY ACTIVITY***

***1. Category of the Play Activity Segment (See Manual pp.4-6)***

| | | |
|---|---|---|
| 1.1 | Sensory Activity | 1 0 99 |
| 1.2 | Gross Motor and Exploratory Activity | 1 0 99 |
| 1.3 | Manipulative, Sorting-Aligning and Construction | 1 0 99 |
| 1.4 | Problem-Solving | 1 0 99 |
| 1.5 | Imitation | 1 0 99 |
| **** 1.6 | Traumatic | 1 0 99 |
| 1.7 | Fantasy | 1 0 99 |
| 1.8 | Game Play | 1 0 99 |

1.9 Art Activity 1 0 99

****** If Traumatic Play is not observed, ratings can stop here.**

**2. Script Description of the Play Activity**

**A. Initiation of the Play by the Child 5 4 3 2 1 99**

**A.1 Requests permission 1 0 99**

**A.2 Begins spontaneously 1 0 99**

**B. Facilitation of the Play by the Child 5 4 3 2 1 99**

**B.1 Gives instructions 1 0 99**

**C. Inhibition of the Play by the Child 5 4 3 2 1 99**

**C.1 Avoidance 1 0 99**

**C.2 Withdrawal 1 0 99**

**C.3 Suppression 1 0 99**

**C.4 Refusal 1 0 99**

**C.5 Ignoring 1 0 99**

***D. Ending of the Play by the Child 5 4 3 2 1 99***

**D.1 Satiation 1 0 99**

**D.2 Interruption 1 0 99**

**D.3 Avoidance 1 0 99**

| | | | | |
|---|---|---|---|---|
| **E** | Overall Level of Contribution of Participants | | | |
| | **1** | Child | | 5 4 3 2 1 99 |
| | | **1.1** | Passive Observer | 5 4 3 2 1 99 |
| | | **1.2** | Parallel Play | 5 4 3 2 1 99 |
| | | **1.3** | Passive Participant | 5 4 3 2 1 99 |
| | | **1.4** | Active Participant | 5 4 3 2 1 99 |
| | **2** | Parent | | 5 4 3 2 1 99 |
| | | **2.1** | Passive Observer | 5 4 3 2 1 99 |
| | | **2.2** | Parallel Play | 5 4 3 2 1 99 |
| | | **2.3** | Passive Participant | 5 4 3 2 1 99 |
| | | **2.4** | Active Participant | 5 4 3 2 1 99 |
| | **3** | Therapist | | 5 4 3 2 1 99 |
| | | **3.1** | Passive Observer | 5 4 3 2 1 99 |
| | | **3.2** | Parallel Play | 5 4 3 2 1 99 |
| | | **3.3** | Passive Participant | 5 4 3 2 1 99 |
| | | **3.4** | Active Participant | 5 4 3 2 1 99 |

**D.4 Play Disruption** **1 0 99**

**D.5 Shift to Non-Play** **1 0 99**

**3. Sphere of the Play Activity**

**A. Autosphere** **5 4 3 2 1 99**

**B. Microsphere** **5 4 3 2 1 99**

**C. Macrosphere** **5 4 3 2 1 99**

*STRUCTURAL ANALYSIS OF PLAY ACTIVITY*

**1. AFFECTIVE COMPONENTS OF THE PLAY ACTIVITY SEGMENT**

**A. Child's Affective Tone**

**A.1 Overall Hedonic Tone** **5 4 3 2 1 99**

**A.2 Spectrum of Affects** **5 4 3 2 1 99**

**A.3 Regulation and Modulation of Affects** **5 4 3 2 1 99**

**A.4 Transition Between Affective States** **5 4 3 2 1 99**

**A.5 Appropriateness of Affective Tone to Content** **5 4 3 2 1 99**

**A.6 Affective Tone Expressed by Child Toward Therapist** **5 4 3 2 1 99**

**B. Affects Expressed by the Child while Playing**

**B.1 Fear** **5 4 3 2 1 99**

**B.2 Anger** **5 4 3 2 1 99**

**B.3 Anxiety/Worry** **5 4 3 2 1 99**

**B.4 Sadness** **5 4 3 2 1 99**

**B.5 Curiosity** **5 4 3 2 1 99**

**B.6 Mischief (Angry eyes & sad mouth)** **5 4 3 2 1 99**

**B.7 Disgust (protruding tongue)** **5 4 3 2 1 99**

**B.8 Disappointment(surprised eyes, sad mouth)** **5 4 3 2 1 99**

**B. 9 Boredom** **5 4 3 2 1 99**

**B.10 Aloofness/Indifference** **5 4 3 2 1 99**

**B.11 Pleasure Happiness (Smile)** **5 4 3 2 1 99**

**B.12 Surprise** **5 4 3 2 1 99**

**B.13 Shame** **5 4 3 2 1 99**

**B.14 Wariness** **5 4 3 2 1 99**

**Specify**
**Others:**_____
_____
_____

| | | |
|---|---|---|
| **A** | Role Representation: People & Play Object | |
| | 1. **Complex Role-Play** | 5 4 3 2 1 99 |
| | **a.** Narrator Play: Child Becomes the Observer of his Play, Commenting on the Play Events | 1 0 99 |
| | **b.** Directorial Play: Child Directs Doll or Miniature Figures to Enact Several Interacting Roles | 1 0 99 |
| | **c.** Collaborative Play: Child collaborates with another person to Enact several Interacting Roles | 1 0 99 |
| | | |
| | **2. Dyadic Role-Play** | 5 4 3 2 1 99 |
| | **a.** Role play with one other active character / person | 1 0 99 |
| | **b.** Child Uses Doll / Toy as active partner | 1 0 99 |
| | | |
| | **3. Single Role-Play** | 5 4 3 2 1 99 |
| | **a.** Child Animates Doll/Toy | 1 0 99 |
| | **b.** Child Pretends He/She is Another Person | 1 0 99 |

## 2. COGNITIVE AND DYNAMIC COMPONENTS OF THE PLAY ACTIVITY SEGMENT

| | | | |
|---|---|---|---|
| 2 Point Scale: | Attribute Present = 1 | Attribute Absent = 0 | |
| 5 Point Scale: | No Evidence = 1 | Considerable Evidence = 4 | Not Scorable or Not Observable = 99 |
| | Minimal Evidence = 2 | Most Characteristic = 5 | |
| | Moderate Evidence = 3 | | |

| | | |
|---|---|---|
| **A** | Role Representation: People & Play Object (Continued) | |
| | **4. Precursor to Role-Play** | 5 4 3 2 1 99 |
| | **a.** Child Imitates His Own Behavior | 1 0 |
| | **b.** Child Imitates Another's Behavior | 1 0 |
| | **c.** Child Uses Other People / Inanimate Object to Imitate what is/was done to him | 1 0 99 |
| | **d.** Child Includes Himself and Doll/Person in the Same Activity (Parallel Roles) | 1 0 99 |
| | | |
| **B** | Stability of Representation: People or Persons (Patient, Therapist, Parents, Other)(See Manual, p21) | |
| | **1.** Voluntary Transformation – Fluid Representation (Several Interchanges) | 5 4 3 2 1 99 |
| | **2.** Voluntary Transformation – Stable Representation (One Interchange) | 5 4 3 2 1 99 |
| | **3.** No Transformation – Stable Role Representation | 5 4 3 2 1 99 |
| | **4.** Involuntary Transformation – Fluid Role Representation (Several Interchanges) | 5 4 3 2 1 99 |
| | **5.** Involuntary Transformation – Stable Role Representation (One Interchange) | 5 4 3 2 1 99 |
| | | |
| **C** | Stability of Representation: Play Object (See Play Manual, p22) | |
| | **1.** Voluntary Transformation – Fluid Representation (Several Interchanges) | 5 4 3 2 1 99 |
| | **2.** Voluntary Transformation – Stable Representation (One Interchange) | 5 4 3 2 1 99 |
| | **3.** No Transformation – Stable Role Representation | 5 4 3 2 1 99 |
| | **4.** Involuntary Transformation – Fluid Role Representation (Several Interchanges) | 5 4 3 2 1 99 |

| | | |
|---|---|---|
| | **5.** Involuntary Transformation – Stable Role Representation (One Interchange) 99 | |
| | | |
| **D** | Use of Play Object | |
| | **1.** Realistic | 5 4 3 2 1 |
| | **2.** Substitution of one Play Object for Another | 5 4 3 2 1 99 |
| | **3.** Miming | 5 4 3 |
| | **4.** Using Object only as a Source of Activity, or only to Stimulate Sensory Input | 5 4 3 2 1 99 |
| | | |
| **E** | Style of Representation: Play Object | |
| | **1.** Realistic | 5 4 3 2 1 99 |
| | **2.** Fantasy / Magical | 5 4 3 2 1 99 |
| | **3.** Bizarre | 5 4 3 2 1 |
| | | |
| **F** | Style In Representation of People (Patient, Therapist, Parents, Sibs, Other) (See Play Manual, p23) | |
| | **1.** Realistic | 5 4 3 2 1 99 |
| | **2.** Fantasy / Magical | 5 4 3 2 1 99 |
| | **3.** Bizarre | 5 4 3 2 1 |

| | | | |
|---|---|---|---|
| 5 Point Scale: | No Evidence = 1 | Moderate Evidence = 3 | Not Scorable or Not Observable = 99 |
| | Minimal Evidence = 2 | Considerable Evidence = 4 | Most Characteristic = 5 |

## A. Topic of the Play Activity Segment

**A.1 Boxing** 1 0 99

**A.2 Cartoon Characters** 1 0 99

**A.3 Doctor** 1 0 99

**A.4 Explorer** 1 0 99

**A.5 Fables/Fairy Tale** 1 0 99

**A.6 Farmer** 1 0 99

| | |
|---|---|
| **A.7 Fire** | **1 0 99** |
| **A.8 Fighting** | **1 0 99** |
| **A. 9 War/Battle** | **1 0 99** |
| **A.10 House** | **1 0 99** |
| **A.11 Killer (murdering toys or persons)** | **1 0 99** |
| **A.12 Natural Forces (thunderstorms, etc.)** | **1 0 99** |
| **A.13 Police** | **1 0 99** |
| **A.14 Director, Commander, President** | **1 0 99** |
| **A.16 Robot** | **1 0 99** |
| **A.17 Store** | **1 0 99** |
| **A.18 Superheros** | **1 0 99** |
| **A.19 Torturer (inflicting pain)** | **1 0 99** |
| **A.20 The Caught One** | **1 0 99** |
| **A.21 The One Who Leaves** | **1 0 99** |

**Specify Others:_____**

**B. Theme of the Play Activity Segment**

| | |
|---|---|
| **B.1 Birth and Giving Birth** | **1 0 99** |
| **B.2 Bodily Damage** | **1 0 99** |
| **B.3 Bodily Function** | **1 0 99** |

**B.4 Breaking Rules** **1 0 99**

**B.5 Caregiving (soothing, comforting)** **1 0 99**

**B.6 Cleaning** **1 0 99**

**B.7 Competence/Mastery** **1 0 99**

**B.8 Competitiveness** **1 0 99**

**B.9 Death** **1 0 99**

**B.10 Destruction** **1 0 99**

**B.11 Drawing** **1 0 99**

**B.12 Feeding** **1 0 99**

**B.13 Grooming** **1 0 99**

**B.14 Making Rules** **1 0 99**

**B.15 Messing** **1 0 99**

**B.16 Reconstruction** **1 0 99**

**B.17 Resurrection** **1 0 99**

**B.18 Separation** **1 0 99**

**B.19 Sexual Activities** **1 0 99**

**B.20 Suffering** **1 0 99**

| C | Level of Relationship Portrayed within the Play Narrative (See Play Manual, p. 24) | |
|---|---|---|
| | **3.1** Self | 5 4 3 2 1 99 |
| | **3.2** Dyadic | 5 4 3 2 1 99 |
| | **3.3** Triadic | 5 4 3 2 1 99 |
| | **3.4** Oedipal | 5 4 3 2 1 99 |

| D | Quality of Relationship Portrayed within the Play Narrative (See Play Manual, pp. 24 - 25) | |
|---|---|---|
| | **4.1** Autonomous | 5 4 3 2 1 99 |
| | **4.2** Parallel | 5 4 3 2 1 99 |
| | **4.3** Dependent | 5 4 3 2 1 99 |
| | **4.4** Twinning | 5 4 3 2 1 99 |
| | **4.5** Malevolent Control | 5 4 3 2 1 99 |
| | **4.6** Destruction | 5 4 3 2 1 99 |
| | **4.7** Annihilation | 5 4 3 2 1 99 |

| E | Use of Language by the Child in the Play Narrative | |
|---|---|---|
| | **5.1** Silence | 5 4 3 2 1 99 |
| | **5.2** Imitation of Sounds, Utterances | 5 4 3 2 1 99 |
| | **5.3** Play with Words | 5 4 3 2 1 99 |
| | **5.4** Verbalization of a Single Role | 5 4 3 2 1 99 |
| | **5.5** Verbalization of Multiple Roles | 5 4 3 2 1 99 |
| | **5.6** Talking During the Play: Within the Metaphor | 5 4 3 2 1 99 |
| | 5.7 Talking During the Play: About the Meaning of the Play | 5 4 3 2 1 99 |
| | **5.8** Talking During the Play: About Something Other Than the Play | 5 4 3 2 1 99 |
| | **5.9** Talking During the Play: Describing the Play | 5 4 3 2 1 99 |

| F | Use of Language by the Adult in the Play Narrative |
|---|---|

| | | |
|---|---|---|
| | **6.1** Silence | 5 4 3 2 1 99 |
| | **6.2** Imitation of Sounds, Utterances | 5 4 3 2 1 99 |
| | **6.3** Play with Words | 5 4 3 2 1 99 |
| | **6.4** Verbalization of a Single Role | 5 4 3 2 1 99 |
| | **6.5** Verbalization of Multiple Roles | 5 4 3 2 1 99 |
| | **6.6** Talking During the Play: Within the Metaphor | 5 4 3 2 1 99 |
| | 6.7 Talking During the Play: About the Meaning of the Play | 5 4 3 2 1 99 |
| | **6.8** Talking During the Play: About Something Other Than the Play | 5 4 3 2 1 99 |
| | **6.9** Talking During the Play: Describing the Play | 5 4 3 2 1 99 |

## 3. DEVELOPMENTAL COMPONENTS OF THE PLAY ACTIVITY SEGMENT

## A. Estimated Developmental Level of the Play (See Appendix of Manual)

| Very Immature | Somewhat Immature | Age Appropriate | Somewhat Advanced | Very Advanced |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

| | | |
|---|---|---|
| **C** | Psycho-Sexual Phase Represented in the Play | |
| | **3.1** Oral Components | 5 4 3 2 1 99 |
| | **3.2** Anal Components | 5 4 3 2 1 99 |
| | **3.3** Phallic Components | 5 4 3 2 1 99 |
| | **3.4** Oedipal Components | 5 4 3 2 1 99 |
| | **3.5** Latency Components | 5 4 3 2 1 99 |

| | | |
|---|---|---|
| **D** | Separation-Individuation Phase Represented in the Play | |
| | **4.1** Differentiation Issues | 5 4 3 2 1 99 |
| | **4.2** Practicing Issues | 5 4 3 2 1 99 |
| | **4.3** Rapprochement Issues | 5 4 3 2 1 99 |
| | **4.4** Object Constancy Issues | 5 4 3 2 1 99 |

***B. Social Interaction with the Adult While Playing**

| | |
|---|---|
| **B.1 Isolated (Unaware)** | **5 4 3 2 1 99** |
| **B.2 Solitary (Aware)** | **5 4 3 2 1 99** |
| **B.3 Parallel** | **5 4 3 2 1 99** |
| **B.4 Reciprocal** | **5 4 3 2 1 99** |
| **B.5 Cooperative** | **5 4 3 2 1 99** |

*FUNCTIONAL ANALYSIS OF THE TRAUMATIC PLAY ACTIVITY*

***A. Traumatic Play Strategies**

**A.1 Cluster One: Re-Enactment with Soothing 5 4 3 2 1 99**

**Coping/Defensive Strategies Observed:**_____
_____
_____
_____

**A.2 Cluster Two: Re-Enactment without Soothing 5 4 3 2 1 99**

**Coping/Defensive Strategies Observed:**_____
_____
_____
_____.

**Functional Analysis of the Traumatic Play Activity (Con't.)**

**A.3 Cluster Three: Overwhelming Re-Enactment 5 4 3 2 1 99**

_____

**_____Coping/Defensive Strategies Observed:**_____

_____

_____

_____

_____

**B. Child's Awareness of Himself as Playing 5 4 3 2 1 99**

---

**Specify Observations that Support to Your Rating:**_____

_____

_____

_____

_____

**Additional Comments:**_____

_____

_____

_____

_____

_____

_____

_____

APPENDIX B

# What I Am Like

Name _____ Age _____ Birthday _____ Group _____
Month Day

Boy or Girl (circle which)

SAMPLE SENTENCE

| | Really True for me | Sort of True for me | | | | Sort of True for me | Really True for me |
|---|---|---|---|---|---|---|---|
| (a) | ☐ | ☐ | Some kids would rather play outdoors in their spare time | BUT | Other kids would rather watch T.V. | ☐ | ☐ |
| 1. | ☐ | ☐ | Some kids feel that they are very *good* at their school work | BUT | Other kids *worry* about whether they can do the school work assigned to them. | ☐ | ☐ |
| 2. | ☐ | ☐ | Some kids find it *hard* to make friends | BUT | Other kids find it's pretty *easy* to make friends. | ☐ | ☐ |
| 3. | ☐ | ☐ | Some kids do very *well* at all kinds of sports | BUT | Other kids *don't* feel that they are very good when it comes to sports. | ☐ | ☐ |
| 4. | ☐ | ☐ | Some kids are *happy* with the way they look | BUT | Other kids are *not* happy with the way they look. | ☐ | ☐ |
| 5. | ☐ | ☐ | Some kids often do *not* like the way they *behave* | BUT | Other kids usually *like* the way they behave. | ☐ | ☐ |
| 6. | ☐ | ☐ | Some kids are often *unhappy* with themselves | BUT | Other kids are pretty *pleased* with themselves. | ☐ | ☐ |
| 7. | ☐ | ☐ | Some kids feel like they are *just as smart* as as other kids their age | BUT | Other kids aren't so sure and *wonder* if they are as smart. | ☐ | ☐ |
| 8. | ☐ | ☐ | Some kids have *alot* of friends | BUT | Other kids *don't* have very many friends. | ☐ | ☐ |

| | Really True for me | Sort of True for me | | | | Sort of True for me | Really True for me |
|---|---|---|---|---|---|---|---|
| 9. | ☐ | ☐ | Some kids wish they could be alot better at sports | BUT | Other kids feel they are good enough at sports. | ☐ | ☐ |
| 10. | ☐ | ☐ | Some kids are *happy* with their height and weight | BUT | Other kids wish their height or weight were *different.* | ☐ | ☐ |
| 11. | ☐ | ☐ | Some kids usually do the *right* thing | BUT | Other kids often *don't* do the right thing. | ☐ | ☐ |
| 12. | ☐ | ☐ | Some kids *don't* like the way they are leading their life | BUT | Other kids *do* like the way they are leading their life. | ☐ | ☐ |
| 13. | ☐ | ☐ | Some kids are pretty *slow* in finishing their school work | BUT | Other kids can do their school work *quickly.* | ☐ | ☐ |
| 14. | ☐ | ☐ | Some kids would like to have alot more friends | BUT | Other kids have as many friends as they want. | ☐ | ☐ |
| 15. | ☐ | ☐ | Some kids think they could do well at just about any new sports activity they haven't tried before | BUT | Other kids are afraid they might *not* do well at sports they haven't ever tried. | ☐ | ☐ |
| 16. | ☐ | ☐ | Some kids wish their body was *different* | BUT | Other kids *like* their body the way it is. | ☐ | ☐ |
| 17. | ☐ | ☐ | Some kids usually *act* the way they know they are *supposed* to | BUT | Other kids often *don't* act the way they are supposed to. | ☐ | ☐ |
| 18. | ☐ | ☐ | Some kids are *happy* with themselves as a person | BUT | Other kids are often *not* happy with themselves. | ☐ | ☐ |
| 19. | ☐ | ☐ | Some kids often *forget* what they learn | BUT | Other kids can remember things *easily.* | ☐ | ☐ |
| 20. | ☐ | ☐ | Some kids are always doing things with *alot* of kids | BUT | Other kids usually do things *by themselves.* | ☐ | ☐ |

| | Really True for me | Sort of True for me | | | | Sort of True for me | Really True for me |
|---|---|---|---|---|---|---|---|
| 21. | ☐ | ☐ | Some kids feel that they are *better* than others their age at sports | BUT | Other kids *don't* feel they can play as well. | ☐ | ☐ |
| 22. | ☐ | ☐ | Some kids wish their physical appearance (how they look) was *different* | BUT | Other kids *like* their physical appearance the way it is. | ☐ | ☐ |
| 23. | ☐ | ☐ | Some kids usually get in *trouble* because of things they do | BUT | Other kids usually *don't* do things that get them in trouble. | ☐ | ☐ |
| 24. | ☐ | ☐ | Some kids *like* the kind of *person* they are | BUT | Other kids often wish they were someone else. | ☐ | ☐ |
| 25. | ☐ | ☐ | Some kids do *very well* at their classwork | BUT | Other kids *don't* do very well at their classwork. | ☐ | ☐ |
| 26. | ☐ | ☐ | Some kids wish that more people their age liked them | BUT | Other kids feel that most people their age *do* like them. | ☐ | ☐ |
| 27. | ☐ | ☐ | In games and sports some kids usually *watch* instead of play | BUT | Other kids usually *play* rather than just watch. | ☐ | ☐ |
| 28. | ☐ | ☐ | Some kids wish something about their face or hair looked *different* | BUT | Other kids *like* their face and hair the way they are. | ☐ | ☐ |
| 29. | ☐ | ☐ | Some kids do things they know they *shouldn't* do | BUT | Other kids *hardly ever* do things they know they shouldn't do. | ☐ | ☐ |
| 30. | ☐ | ☐ | Some kids are very *happy* being the way they are | BUT | Other kids wish they were *different.* | ☐ | ☐ |
| 31. | ☐ | ☐ | Some kids have *trouble* figuring out the answers in school | BUT | Other kids almost *always* can figure out the answers. | ☐ | ☐ |
| 32. | ☐ | ☐ | Some kids are *popular* with others their age | BUT | Other kids are *not* very popular. | ☐ | ☐ |

| | Really True for me | Sort of True for me | | | | Sort of True for me | Really True for me |
|---|---|---|---|---|---|---|---|
| 33. | ☐ | ☐ | Some kids *don't* do well at new outdoor games | BUT | Other kids are *good* at new games right away. | ☐ | ☐ |
| 34. | ☐ | ☐ | Some kids think that they are good looking | BUT | Other kids think that they are not very good looking. | ☐ | ☐ |
| 35. | ☐ | ☐ | Some kids behave themselves very well | BUT | Other kids often find it hard to behave themselves. | ☐ | ☐ |
| 36. | ☐ | ☐ | Some kids *are* not very happy with the way they do alot of things | BUT | Other kids think the way they do things is *fine.* | ☐ | ☐ |

Susan Harter, Ph.D., University of Denver, 1985

## TEACHER'S RATING SCALE OF CHILD'S ACTUAL BEHAVIOR

(Parallels the self-perception profile for children)

Child's name _____ Class/grade/group _____ Rater _____

For each child, please indicate what you feel to be his/her actual competence on each question, in your opinion. First decide what kind of child he or she is like, the one described on the left or right, and then indicate whether this is just sort of true or really true for that individual. Thus, for each item, check *one* of four boxes.

| | Really True | Sort of True | | | | Sort of True | Really True |
|---|---|---|---|---|---|---|---|
| 1. | ☐ | ☐ | This child is really good at his/her school work | OR | This child can't do the school work assigned. | ☐ | ☐ |
| 2. | ☐ | ☐ | This child finds it hard to make friends | OR | For this child it's pretty easy. | ☐ | ☐ |
| 3. | ☐ | ☐ | This child does really well at all kinds of sports | OR | This child isn't very good when it comes to sports. | ☐ | ☐ |
| 4. | ☐ | ☐ | This child is good-looking | OR | This child is not very good-looking. | ☐ | ☐ |
| 5. | ☐ | ☐ | This child is usually well-behaved | OR | This child is often not well-behaved. | ☐ | ☐ |
| 6. | ☐ | ☐ | This child often forgets what s/he learns | OR | This child can remember things easily. | ☐ | ☐ |
| 7. | ☐ | ☐ | This child has alot of friends | OR | This child doesn't have many friends. | ☐ | ☐ |
| 8. | ☐ | ☐ | This child is better than others his/her age at sports | OR | This child can't play as well. | ☐ | ☐ |
| 9. | ☐ | ☐ | This child has a nice physical appearance | OR | This child doesn't have such a nice physical appearance. | ☐ | ☐ |
| 10. | ☐ | ☐ | This child usually acts appropriately | OR | This child would be better if s/he acted differently. | ☐ | ☐ |
| 11. | ☐ | ☐ | This child has trouble figuring out the answers in school | OR | This child almost always can figure out the answers. | ☐ | ☐ |
| 12. | ☐ | ☐ | This child is popular with others his/her age | OR | This child is not very popular. | ☐ | ☐ |
| 13. | ☐ | ☐ | This child doesn't do well at new outdoor games | OR | This child is good at new games right away. | ☐ | ☐ |
| 14. | ☐ | ☐ | This child isn't very good looking | OR | This child is pretty good-looking. | ☐ | ☐ |
| 15. | ☐ | ☐ | This child often gets in trouble because of things he/she does | OR | This child usually doesn't do things that get him/her in trouble. | ☐ | ☐ |

APPENDIX C

# TEACHER'S REPORT FORM FOR AGES 6-18

For office use only
ID #

Your answers will be used to compare the pupil with other pupils whose teachers have completed similar forms. The information from this form will also be used for comparison with other information about this pupil. Please answer as well as you can, even if you lack full information. Scores on individual items will be combined to identify general patterns of behavior. Feel free to print additional comments beside each item and in the spaces provided on page 2. ***Please print, and answer all items.***

| | | | |
|---|---|---|---|
| PUPIL'S FULL NAME First Middle Last | | | **PARENTS' USUAL TYPE OF WORK, even if not working now** *(Please be specific — for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.)* |
| PUPIL'S GENDER ❒ Boy ❒ Girl | PUPIL'S AGE | PUPIL'S ETHNIC GROUP OR RACE | FATHER'S TYPE OF WORK _____ |
| | | | MOTHER'S TYPE OF WORK _____ |
| TODAY'S DATE Mo._____ Date_____ Yr._____ | | PUPIL'S BIRTHDATE (if known) Mo._____ Date_____ Yr._____ | **THIS FORM FILLED OUT BY:** (*print your full name*) |
| GRADE IN SCHOOL _____ | NAME AND ADDRESS OF SCHOOL _____ _____ | | Your gender: ❒ Male ❒ Female<br>Your role at the school:<br>❒ Classroom Teacher ❒ Counselor<br>❒ Special Educator ❒ Administrator<br>❒ Teacher's Aide ❒ Other (specify): |

**I.** **For how many months have you known this pupil? _____ months**

**II.** **How well do you know him/her?** 1. ❒ Not Well 2. ❒ Moderately Well 3. ❒ Very Well

**III.** **How much time does he/she spend in your class or service per week?**

**IV.** **What kind of class or service is it? (Please be specific, e.g., regular 5th grade, 7th grade math, learning disability, counseling, etc.)**

**V.** **Has he/she ever been referred for special class placement, services, or tutoring?**
❒ Don't Know 0. ❒ No 1. ❒ Yes — what kind and when?

**VI.** **Has he/she repeated any grades?** ❒ Don't Know 0. ❒ No 1. ❒ Yes — grades and reasons:

**VII.** **Current academic performance** — list academic subjects and check box that indicates pupil's performance for each subject:

| Academic subject | 1. Far below grade | 2. Somewhat below grade | 3. At grade level | 4. Somewhat above grade | 5. Far above grade |
|---|---|---|---|---|---|
| 1. _____ | ❒ | ❒ | ❒ | ❒ | ❒ |
| 2. _____ | ❒ | ❒ | ❒ | ❒ | ❒ |
| 3. _____ | ❒ | ❒ | ❒ | ❒ | ❒ |
| 4. _____ | ❒ | ❒ | ❒ | ❒ | ❒ |
| 5. _____ | ❒ | ❒ | ❒ | ❒ | ❒ |
| 6. _____ | ❒ | ❒ | ❒ | ❒ | ❒ |

***Be sure you answered all items. Then see other side.***

*Please print. Be sure to answer all items.*

| VIII. Compared to typical pupils of the same age: | 1. Much less | 2. Somewhat less | 3. Slightly less | 4. About average | 5. Slightly more | 6. Somewhat more | 7. Much more |
|---|---|---|---|---|---|---|---|
| 1. How hard is he/she working? | ❒ | ❒ | ❒ | ❒ | ❒ | ❒ | ❒ |
| 2. How appropriately is he/she behaving? | ❒ | ❒ | ❒ | ❒ | ❒ | ❒ | ❒ |
| 3. How much is he/she learning? | ❒ | ❒ | ❒ | ❒ | ❒ | ❒ | ❒ |
| 4. How happy is he/she? | ❒ | ❒ | ❒ | ❒ | ❒ | ❒ | ❒ |

**IX. Most recent achievement test scores** (optional):

| Name of test | Subject | Date | Percentile or grade level obtained |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**X. IQ, readiness, or aptitude tests** (optional):

| Name of test | Date | IQ or equivalent scores |
|---|---|---|
| | | |
| | | |
| | | |

**Does this pupil have any illness or disability (either physical or mental)?** ❒ No ❒ Yes— please describe:

**What concerns you most about this pupil?**

**Please describe the best things about this pupil:**

**Please feel free to write any comments about this pupil's work, behavior, or potential, using extra pages if necessary.**

***Please print. Be sure to answer all items.***

Below is a list of items that describe pupils. For each item that describes the pupil ***now or within the past 2 months,*** please circle the ***2*** if the item is ***very true or often true*** of the pupil. Circle the ***1*** if the item is ***somewhat or sometimes true*** of the pupil. If the item is ***not true*** of the pupil, circle the ***0***. Please answer all items as well as you can, even if some do not seem to apply to this pupil.

**0 = Not True (as far as you know) 1 = Somewhat or Sometimes True 2 = Very True or Often True**

0 1 2 1. Acts too young for his/her age
0 1 2 2. Hums or makes other odd noises in class
0 1 2 3. Argues a lot
0 1 2 4. Fails to finish things he/she starts
0 1 2 5. There is very little that he/she enjoys
0 1 2 6. Defiant, talks back to staff
0 1 2 7. Bragging, boasting
0 1 2 8. Can't concentrate, can't pay attention for long
0 1 2 9. Can't get his/her mind off certain thoughts; obsessions (describe): _____
_____
0 1 2 10. Can't sit still, restless, or hyperactive
0 1 2 11. Clings to adults or too dependent
0 1 2 12. Complains of loneliness
0 1 2 13. Confused or seems to be in a fog
0 1 2 14. Cries a lot
0 1 2 15. Fidgets
0 1 2 16. Cruelty, bullying, or meanness to others
0 1 2 17. Daydreams or gets lost in his/her thoughts
0 1 2 18. Deliberately harms self or attempts suicide
0 1 2 19. Demands a lot of attention
0 1 2 20. Destroys his/her own things
0 1 2 21. Destroys property belonging to others
0 1 2 22. Difficulty following directions
0 1 2 23. Disobedient at school
0 1 2 24. Disturbs other pupils
0 1 2 25. Doesn't get along with other pupils
0 1 2 26. Doesn't seem to feel guilty after misbehaving
0 1 2 27. Easily jealous
0 1 2 28. Breaks school rules
0 1 2 29. Fears certain animals, situations, or places other than school (describe):_____
_____
0 1 2 30. Fears going to school
0 1 2 31. Fears he/she might think or do something bad
0 1 2 32. Feels he/she has to be perfect
0 1 2 33. Feels or complains that no one loves him/her
0 1 2 34. Feels others are out to get him/her
0 1 2 35. Feels worthless or inferior
0 1 2 36. Gets hurt a lot, accident-prone
0 1 2 37. Gets in many fights
0 1 2 38. Gets teased a lot
0 1 2 39. Hangs around with others who get in trouble
0 1 2 40. Hears sounds or voices that aren't there (describe):_____
_____
0 1 2 41. Impulsive or acts without thinking
0 1 2 42. Would rather be alone than with others
0 1 2 43. Lying or cheating
0 1 2 44. Bites fingernails
0 1 2 45. Nervous, high-strung, or tense
0 1 2 46. Nervous movements or twitching (describe): _____
_____
0 1 2 47. Overconforms to rules
0 1 2 48. Not liked by other pupils
0 1 2 49. Has difficulty learning
0 1 2 50. Too fearful or anxious
0 1 2 51. Feels dizzy or lightheaded
0 1 2 52. Feels too guilty
0 1 2 53. Talks out of turn
0 1 2 54. Overtired without good reason
0 1 2 55. Overweight
56. Physical problems ***without known medical cause:***
0 1 2 a. Aches or pains (***not*** stomach or headaches)
0 1 2 b. Headaches
0 1 2 c. Nausea, feels sick
0 1 2 d. Eye problems (***not*** if corrected by glasses) (describe):_____
_____
0 1 2 e. Rashes or other skin problems
0 1 2 f. Stomachaches
0 1 2 g. Vomiting, throwing up
0 1 2 h. Other (describe):_____
_____
_____

 ***Be sure you answered all items. Then see other side.***

*Please print. Be sure to answer all items.*

**0 = Not True (as far as you know)  1 = Somewhat or Sometimes True  2 = Very True or Often True**

0 1 2 57. Physically attacks people
0 1 2 58. Picks nose, skin, or other parts of body (describe):_____
_____
0 1 2 59. Sleeps in class
0 1 2 60. Apathetic or unmotivated
0 1 2 61. Poor school work
0 1 2 62. Poorly coordinated or clumsy
0 1 2 63. Prefers being with older children or youths
0 1 2 64. Prefers being with younger children
0 1 2 65. Refuses to talk
0 1 2 66. Repeats certain acts over and over; compulsions (describe):_____
_____
0 1 2 67. Disrupts class discipline
0 1 2 68. Screams a lot
0 1 2 69. Secretive, keeps things to self
0 1 2 70. Sees things that aren't there (describe):
_____
_____
0 1 2 71. Self-conscious or easily embarrassed
0 1 2 72. Messy work
0 1 2 73. Behaves irresponsibly (describe):_____
_____
_____
0 1 2 74. Showing off or clowning
0 1 2 75. Too shy or timid
0 1 2 76. Explosive and unpredictable behavior
0 1 2 77. Demands must be met immediately, easily frustrated
0 1 2 78. Inattentive or easily distracted
0 1 2 79. Speech problem (describe):_____
_____
0 1 2 80. Stares blankly
0 1 2 81. Feels hurt when criticized
0 1 2 82. Steals
0 1 2 83. Stores up too many things he/she doesn't need (describe):_____
_____
_____
0 1 2 84. Strange behavior (describe):_____
_____
0 1 2 85. Strange ideas (describe):_____
_____
0 1 2 86. Stubborn, sullen, or irritable
0 1 2 87. Sudden changes in mood or feelings
0 1 2 88. Sulks a lot
0 1 2 89. Suspicious
0 1 2 90. Swearing or obscene language
0 1 2 91. Talks about killing self
0 1 2 92. Underachieving, not working up to potential
0 1 2 93. Talks too much
0 1 2 94. Teases a lot
0 1 2 95. Temper tantrums or hot temper
0 1 2 96. Seems preoccupied with sex
0 1 2 97. Threatens people
0 1 2 98. Tardy to school or class
0 1 2 99. Smokes, chews, or sniffs tobacco
0 1 2 100. Fails to carry out assigned tasks
0 1 2 101. Truancy or unexplained absence
0 1 2 102. Underactive, slow moving, or lacks energy
0 1 2 103. Unhappy, sad, or depressed
0 1 2 104. Unusually loud
0 1 2 105. Uses alcohol or drugs for nonmedical purposes (***don't*** include tobacco) (describe):_____
_____
0 1 2 106. Overly anxious to please
0 1 2 107. Dislikes school
0 1 2 108. Is afraid of making mistakes
0 1 2 109. Whining
0 1 2 110. Unclean personal appearance
0 1 2 111. Withdrawn, doesn't get involved with others
0 1 2 112. Worries
113. Please write in any problems the pupil has that were not listed above.
0 1 2 _____
0 1 2 _____
0 1 2 _____



***Please be sure you answered all items.***