THE HEALING POWER OF PLAY

Working with Abused Children

ELIANA GIL

"Eliana Gil occupies an unparalleled position among professionals in the child abuse field. No one has worked longer, more faithfully, and more responsibly with such a diverse array of abusive interactions. In this work, Dr. Gil addresses at once the needs of children, the role of supportive caretakers, and the therapeutic antidotes to the many variations of inflicted trauma."
— *Roland C. Summit, M.D.*

"After reading THE HEALING POWER OF PLAY, child therapists from every professional background will feel better equipped to confront the enormous challenge of treating the abused child....Dr. Gil's readable guide should inspire the field and thereby benefit all of our patients."
— *Spencer Eth, M.D.*

Children traumatized by either abuse or neglect have special therapeutic needs. They can be difficult to engage for a variety of reasons: many have been frightened into silence, and many have had their trust in adults betrayed; they may be hostile and acting out, and, if young, they may lack the sophistication of language or sexual terminology to clearly impart what has occurred. Whether or not children know how to communicate directly with a therapist, all children know how to play. This book describes how therapists can both facilitate constructive play therapy and intervene in posttraumatic play to help children who have been traumatized by abuse or neglect achieve a positive resolution.

Combining theory with a practical "how-to" approach, this volume reviews traditional techniques of play therapy and describes therapeutic aids to enhance children's capacity to communicate. To clearly illustrate how clinicians can tailor responses to a particular child, six detailed clinical vignettes of trauma from different types of abuse are presented along with step-by-step guidelines for assessment and intervention.

With its valuable insights and practical guidance, this book is an essential resource for all mental health professionals who work with abused children. Those who work with adult survivors will learn much of value for treating the "child within." The book also serves as a text for advanced courses on child therapy, child development, family therapy, domestic violence, or child abuse. Other professionals who come into contact with abused children, such as protective service workers, medical professionals, clergy, teachers, and day-care professionals, will find much of interest.

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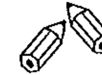
from answering questions or giving directives. Axline (1964) demonstrates the use of nondirective therapy in her classic work *Dibbs in Search of Self.* Nondirective techniques are always helpful in the diagnostic phase of treatment and, as Guerney (1980) points out, have been shown to be effective with a wide range of problems.

The basic difference between the nondirective and directive approaches rests in the clinician's activity in the therapy. Directive therapists structure and create the play situation, attempting to elicit, stimulate, and intrude upon the child's unconscious, hidden processes or overt behavior by challenging the child's defensive mechanisms and encouraging or leading the child in directions that are seen as beneficial. Nondirective therapists are "actually controlled, always centered on the child, and attuned to his/her communications, even the subtle ones" (Guerney, 1980, p. 58). Directive therapies are by nature more short-term, more symptom-oriented, and less dependent on the therapeutic transference than are nondirective therapies.

The directive therapies are multitudinous and include, among other things, behavior therapies, Gestalt therapy, filial therapy, and family therapy. Certain specific techniques, such as puppet play, story-telling techniques, certain board games, and various forms of artistic endeavor, lend themselves to being employed in therapy in different ways: A nondirective therapist might provide the child with ample opportunities for art work or story telling with puppets whereas a directive therapist might ask the child to draw specific things or tell an exact story.



The Treatment of Abused Children

TREATMENT CONSIDERATIONS IN WORKING WITH ABUSED CHILDREN

When assessing the treatment needs of abused children and formulating treatment plans, it is vital to consider a number of issues such as, among other things, the phenomenological impact of the abuse, the family's level of dysfunction, the environmental stability, the age of the child, and the child's relationship to the offender.

The actual act of abuse is usually only one of myriad experiences the child endures. More often than not, the recognition and reporting of the abuse to the authorities sets into motion a number of legal and protective interventions that are perplexing and anxiety-provoking to the child. Consequently, the treatment of abused children is multidimensional and will likely include an array of services including individual, parent–child, group, and family therapy—all delivered within the context of social service and legal systems that operate within their own regulations and limitations.

The therapy of abused children includes the monitoring of risk factors, coordination with a variety of agencies, adherence to requests for periodic reports, and a focus on processing of the child and family's trauma, as well as intervention in intricate family dynamics, observation of parent–child interactions, work with foster families or other temporary caretakers for the child, advocacy efforts, testifying in court as needed, and other special activities that are discussed in the final chapter of this book.

The Phenomenological Experience

First and foremost, it is urgent to view each child's experience as unique. References were made to "mediators of abuse" earlier in this book, and there might be a temptation to judge the impact of abuse by certain yardsticks, such as the duration of the abuse, the severity, how many symptoms arise, who the perpetrator was, or how the child appears. The reality is that children react differently, and although the research can serve as a kind of global map of common repercussions, only close examination will reveal the subtle landmarks.

I once worked with a family of five children, ages two, four, seven, ten, and fifteen, whose home was burned down as a result of a freak gas explosion. The parents made swift and appropriate responses, buying the children duplicates of their favorite things, talking to them in a group about the experience, and bringing themselves and the children for some family counseling sessions. The parents commanded authority, coped well with their stress, and conveyed positive feelings to the children, centering on the fact that they had all survived and that that was the most miraculous and important thing. The parents also had the financial means to rent a comfortable home, and their insurance provided substantial compensation for erecting a new home. The children were involved in the plans and were awarded the right to "design" their own space if interested. The counseling sessions were almost redundant, since the parents had engaged the children in effective verbal communication. It

was clear this was a close and communicative family, and their skills were well applied during the crisis. Some of the younger children's art work and play had elements of reenactment, as they drew fires and tumbled buildings. The children had also had fretful sleep, particularly the older ones, who seemed to have a greater understanding of how close they had come to death.

After six or eight conjoint meetings with the family, the parents and I agreed that I would be available to the children should any concerns arise in the future. Six months later the parents brought their 7-year-old son into therapy because he was unable to sleep, had lost his appetite (and 12 pounds), and appeared to go into alternating states of panic and what the parents described as "spacey" behavior—he sucked his thumb in the corner and had a fixed stare. In addition, he was afraid of the stove, the fireplace (which had not been used), and even the hot water in the tub. He flinched at any slight noise, and he had stopped playing outside. His brothers and sisters were not able to elicit his participation in either conversation or play. This is an example of how the same event, with subsequent similar responses, can be experienced differently by one child than by others when there has been no previous indication of marked personality differences among the children. The only explanation is the phenomenological nature of an individual's perception, integration, and processing of single or cumulative events, and this uniqueness commands great respect.

No matter what initial intervention is made, there is an inherent advantage in setting the therapeutic context for future work. Many of my child clients have had "discontinuous therapy," which allows and encourages families to return to therapy for "checkups" on an as-needed basis. However, it is my belief that the sooner a trauma victim enters treatment, the better.

Terr (1990) is quick to point out how quickly children and their families can recover from a trauma and cautions against postponing treatment:

> Putting off treatment for trauma is about the worst thing one can do. Trauma does not ordinarily get "better" by itself.

> It burrows down further and further under the child's defenses and coping strategies. Suppression, displacement, overgeneralization, identification with the aggressor, splitting, passive-into-active, undoing, and self-anesthesia take over. The trauma may actually come to "look" better after all these coping and defense mechanisms go into operation. But the trauma will continue to affect the child's character, dreams, feelings about sex, trust, and attitudes about the future. (p. 293)

All presuppositions about abused children must be halted in the face of a new child victim. Assuming a child feels angry, sad, betrayed, depressed, or anything else is counterproductive. We must enter the assessment phase free from biases about the *general* effects of victimization or traumatization and enter the realm of learning from each child's singular experience. Only the children can tell or show us what meaning the experience has had to them. Only they can allow us to understand the incredible survival instincts of victims/survivors. They will show or tell us what they need although verbal directives are few and far between.

The clinician must set aside his/her own agenda and treatment plans must be individually designed and revised on a continuous basis.

The Family's Level of Dysfunction

The therapist may or may not have access to the abusive family when work is done with abused children. Abusive families, particularly neglectful ones, are frequently multi-problem families with high levels of dysfunction.

Even if the clinician has access to the family, their level of functioning might be so low as to minimize the impact of therapy. Therefore, it becomes critical for the clinician to lower expectations and devise realistic goals. Also, the clinician must take great care to ascertain how the child's progress is viewed at home. For example, the clinician may encourage the child to express his/her feelings and send the child into an environment where verbalizing feelings will elicit punishment. If the family is unresponsive and continues to organize around multiple crises, the most helpful

interventions will be those designed to help the child cope with the realities of the environment.

Monitoring Risk Factors

Providing therapy to abused children, particularly those who have not been removed from their families, involves a special focus on risk factors to both the parents and the child clients. As Green (1988) notes, "Any plan for the treatment of child abuse must be designed to create a safe environment for the child and to modify the potentiating factors underlying the maltreatment...An effective treatment program must deal specifically with the parental abuse-proneness, the characteristics of the child that make him vulnerable, and the environmental stress that triggers the abusive interaction" (p. 859). It is therefore obligatory to have a clear understanding of the factors that led to the abuse and to have done a comprehensive review of these factors with the parents. For example, if one of the precipitators of the abuse was a parent's alcohol abuse, efforts must be made to monitor the parent's adherence to alcohol treatment programs. If one of the conditions of the court is that the child attend a daily child care program, it is important to verify that this is, in fact, transpiring. If the parental treatment is being conducted by another clinician, the child's clinician is advised to obtain contact with the relevant professionals and coordinate the risk management aspect of the therapeutic intervention.

Environmental Stability

As mentioned earlier, abusive families characteristically have a wide range of problems. They may have housing problems or frequent relocations, live in shelters, or even be homeless. The primary focus of the treatment is on providing the family and the child with as much information on resources and coping skills as possible. Clinicians who choose to work with abusive families must familiarize themselves with the multitude of prevention and treatment programs that have surfaced over the past 15 years. Up-to-date information is provided by local Child Abuse Councils, easily found in the

telephone directory. In addition, a National Child Abuse Hotline maintains current resource information (1-800-4-A-CHILD).

The Age of the Child

It is difficult to conduct play therapy with children under the age of two. Two- to three-year-olds differ immensely in cognitive, motor, and verbal abilities. Children in this age group should be assessed to determine how amenable they are to therapy. Little is written about the treatment of young children, although a number of professionals are beginning to gain and share their expertise (MacFarlane, Waterman, et al., 1986). Even children this young can exhibit post-traumatic play and reveal unconscious fears and concerns through their play.

The Child's Relationship to the Offender

As noted earlier, the closer the relationship between the child and the offender, the more potentially traumatic the event is to the child. The clinician is once again advised to tread lightly, suspending personal judgments about the child's perpetrator. The child must sense that any and all feelings he/she may have about the perpetrator are acceptable to the clinician.

If, however, the child appears to be fixated on just one feeling, the clinician can comment on that and gently direct the child to other possible emotions. I once saw a young girl who had been virtually abandoned by her mother and had only sporadic contact with her. She was adamant that she hated her mother, thought she was useless, and never wanted to have anything to do with her. One day I softly said, "You are really good at telling me about how angry you are at your mother. And I bet you would be just as good at telling me some of the other feelings you have or have had towards her." She quickly retorted, "I don't feel anything else about her." I added, "Maybe not now, but I bet when you were little there might have been some other feelings." "Well yeah,

'cause I didn't know any better." Then I proceeded to ask what those feelings had been, and she cried a little as she described memories of wanting to go everywhere with her mother, and of feeling worried about her when she went out drinking. Just because a child emphasizes one primary feeling doesn't mean that other feelings might not be just beneath the surface.

Another child, also overtly hostile toward his mother, was unresponsive to queries about other feelings. I brought out my cards with "feeling pictures" (Communication Skillbuilders, 1988) and fanned them out in my hands. "Pick one," I prompted. When he did I asked him to tell me a time he had felt the (chosen) feeling about his mom. Because it was a game and there were explicit rules, the child simply acquiesced, and a lot of rich material sprang forward.

Treatment of the Child in His/Her Environment

Another difference in treating this population is the frequent instability of the environment. Often children are placed in foster homes (or a series of foster homes), group homes, or residential facilities. I have had more than one treatment interrupted by an abrupt transfer of my child client to another county or state.

Foster homes differ in quality. I have had contact with many highly qualified professionals, who have become part of the treatment team. Children who are removed from their home suffer the additional impact of separation from parents and familiar environments and usually need help dealing with separation anxiety, concern for their parents, and loyalty conflicts (Itzkowitz, 1989).

The therapy must include an assessment of the child's environment and an attempt to coordinate informational exchange with the alternative family on a regular basis. My experience has been that most foster parents welcome contact with the therapist, appreciate being regarded as a member of a professional team, offer many valuable insights, and respond well to suggestions regarding the child. Too often, foster families or other caretakers are not contacted, and helpful information is unavailable to the clinician.

Discontinuous Therapy

As mentioned previously, working with abused children may include intermittent participation from the child. Parents may withdraw the child from treatment once the court mandate is no longer present, or financial restrictions may influence the parent's decision to terminate the therapy. In addition, the child may use the therapy well for a period of time and later shift to periods when she/he does not seem to want to come or does not engage in therapeutic play. These are but some of the circumstances that can precipitate the use of discontinuous therapy. Nevertheless, children can benefit greatly from these short-term, task-focused, involvements with therapy.

The Clinician's Gender

Children who are abused may develop idiosyncratic responses to persons of the same sex as their abusers, including clinicians. In some instances it may be advantageous to transfer the child so this issue can be resolved. For example, I worked with a boy victim who was raped by his father for over a year. This child was in therapy with me for over 2 years, became well adjusted to his long-term foster placement, processed the trauma issues, and developed a sense of competence, safety, and well-being. The combination of a safe environment and therapy worked wonders; yet the boy always shied away from men and, I observed, exhibited startle responses when he saw a male therapist in my office. His play indicated a reticence toward men and a preference for contact with women. Unfortunately, the foster parent was an unmarried woman and the boy's teachers had been women, except for the physical education teacher. The boy wanted to avoid physical education because of the teacher, and the school gave him a special dispensation based on his history. Thus, the child had effectively managed to expel all men from his life.

I decided to transfer the boy to a male therapist. At first he resisted vehemently, but the joint sessions with the male therapist intrigued him, and slowly but surely, I could see

him explore the boundaries of the new situation, asking questions of the male therapist, handing him toys, and making definitive statements about his preferences. Finally, the day came for his first "alone" visit with the male therapist; I waited outside the office at a designated place. He came out of the office twice to make sure I was there but tolerated the visit fairly well. The therapy continued for another year, and even though I felt the child had already made great strides, his progress with the male therapist was very rewarding. The child became physically active, appeared to grow due to his more erect stature, and joined a soccer team. He no longer avoided men and had established a good relationship with the soccer coach.

Symptoms of Distress and Treatment Modalities

Relatively little has been written about the treatment of young abused children although the past 2 years has seen a welcome surge in books about therapy with sexually abused and traumatized children (Friedrich, 1990; James, 1989; Johnson, 1989; Terr, 1990). Treatment of sexually abused children has probably been the most widely researched and documented aspect of treatment of abused children, and many of these findings are applicable to victims of other types of abuse. Long (1986), for example, discusses relevant issues in the treatment of sexually abused children: importance of teaming with the child's mother; inappropriate attachment behavior; infant regressive behavior; need for body contact and body awareness; and need for education on feelings. All of these areas are addressed in treatment of abused and neglected children in general. Porter, Blick, and Sgroi (1982), referring to the psychological issues that must be dealt with in work with sexually abused children, list "damaged goods" syndrome, guilt, fear, depression, low self-esteem, poor social skills, repressed anger, and hostility. Added to these are traits most characteristic of incest victims: impaired ability to trust, blurred role boundary and role confusion, and pseudomaturity coupled with failure to accomplish developmental tasks, self-mastery, and control. Again, all victims of

child abuse and neglect will benefit from the clinician's focus on these matters. Burgess, Holstrom, and McCausland (1978) emphasize the importance of decreasing the child's anxiety and attempting to engender trust as a first step in the treatment process. MacVicar (1979) stresses that sexually abused children often confuse sex with affection and need some help understanding sexuality. Waterman (1986), reviewing the literature on the treatment of sexually abused children, notes that many treatment modalities have been used, including family systems; a combination of behavior therapy for perpetrator, marital therapy, and family therapy; individual short- or long-term child therapy; group therapy; and art or play therapy. Terr (1990) notes that traumatized children are characterized by emotions of terror, rage, denial and numbing, unresolved grief, shame, and guilt. She also states that such children develop "traumatophobia," or fear of fear itself. This fear that springs from psychic trauma, she says, "makes arch conservatives out of formerly flexible children" (p. 37). Beezeley, Martin, and Alexander (1976), in a study of 12 physically abused children who stayed in treatment over one year, found that children's improvement was seen in increased ability to trust, increased ability to delay gratification, increased self-esteem, increased ability to verbalize feelings, and increased capacity for pleasure. Beezley and associates found that progress was greatest if the parents were willing to let the child make changes and were willing to make changes themselves and if the therapist could influence the environment, that is, the school setting, the playroom, and the child's relationships with others (p. 210). Mann and McDermott (1983) point out that the common areas of psychological disturbance requiring clinical attention are fear of physical assault or fear of abandonment, leading to depression and anxiety; failure to meet parents' distorted expectations, leading to defective object relationships, struggles over dependency, and internalization of a "bad child" self-image with poor self-esteem; difficulty achieving separation and autonomy; and prolonged and heightened separation anxiety and ambivalence over attachment to caretakers as a result of multiple rejections and out-of-home placements, including hospitalizations (p. 285).

I can't imagine a situation in which an abused child would not require or benefit from individual therapy. The experience of victimization or traumatization is painful, alarming, and confusing enough to warrant speedy intervention. The individual therapy, which includes an ongoing assessment, may be short-term and may precipitate the need for family or group work. However, in my view, every abused child deserves a one-on-one experience with a trained professional.

At the same time, if the child is to be reunited with a formerly abusive family—whether it be physical or sexual abuse, neglect, or emotional maltreatment—it becomes requisite to see the family with the child present. In addition, if the child has been abused outside the home, the entire family experiences the impact of the traumatic event, and all members require assistance.

Probably nowhere else is the direct observation of the parent–child relationship as indispensable as it is in situations of child abuse. Many inexperienced clinicians have been baffled to learn of a new abusive incident after the parents had religiously reported that they were using better disciplinary techniques and had not engaged in overt conflicts. A parent can state that she/he has been making calm and reasonable requests of a child, but direct observation may lead to a different conclusion. The clinician may find that while some improvement has been made, the tone and pitch of the parent's voice, combined with nonverbal communication, continue to be harsh enough to terrify the child and discourage voluntary compliance.

Family therapists encourage the presence of all family members in therapy sessions, but they have been considerably lax in demonstrating methods for conducting family sessions with very young children (Scharff & Scharff, 1987). The most typical family therapy scenario consists of the family therapist meeting with the adults in the family while the young children are relegated to the corner with toys or

drawing materials. Scharff and Scharff (1987) discuss family therapy with very young children, offering interesting and useful suggestions (p. 285).

Social Service Agencies and the Courts

Working with abusive families often necessitates contact with court and social service agency personnel, who are responsible for overseeing the protection of the child. This type of contact can be seen as an act of treason by parents who are nonvoluntary therapy clients. In order to maximize the chances of forming a therapeutic alliance (often an oxymoron) with these clients, I usually limit my contact with social service agencies to written communications and show the letters to my clients prior to mailing. In this way, triangulation can be avoided and the clients may feel less helpless. It's probably too much to expect that this simple action will elicit total trust, but most clients respond well to this method of compliance with the authorities.

In working with abusive families and children, it is important to ascertain what the authorities expect from them. In other words, what specific behaviors or activities does the court or social service agency expect from the family to avoid the child's removal or to bring about reunification. Behavioral objectives, rather than broad goals, must be outlined. For example, "The parents should get along better" is vague and can be better explained with an explicit statement like "The parents must stop hitting and begin to have communication with each other, resulting in at least two decisions a week about the children and two decisions a week about how to spend their money." This specificity will greatly aid the clinician in assessing progress and in implementing treatment in a purposeful way.

Confidentiality and the Reporting Law

The mental health professional encounters a serious dilemma when treating allegedly abused or identified abused children. The dilemma originates because clinicians create an environment where, hopefully, a child feels safe and comfortable enough to share his/her inner thoughts, worries, or fears. When this atmosphere is accomplished by competent professionals and the child verbally or nonverbally shares or signals that he/she is being abused, the therapist is legally obligated to convey that information to the authorities. The child may feel betrayed by this apparent breach of trust and may withdraw into the uncomfortable or familiar position of having to decide what information can and cannot be divulged. And yet the reality is that the child abuse law was developed as a mechanism to obtain necessary protection for vulnerable children.

I find it necessary and desirable to tell the children from the outset that there are limits to confidentiality, that clinicians have certain legal obligations that supersede the obligations of confidentiality. This can be done in a matter-of-fact way in simple language, for example: "Everything we talk about in here is private. I won't repeat things that you tell me to anyone unless I get worried about a few things. I will have to tell someone if I think you are hurting yourself, hurting someone else, or if someone is hurting you, including your parents or brothers and sisters. 'Hurting' means different things like hitting or touching on private parts of the body." Then the child should be encouraged to ask questions or get further clarification. The clinician's answers should be confined to what is known. One of the ways that children will definitely feel betrayed is if the clinician predicts or promises a particular outcome, for example, the child will or will not stay at home or protective services or police will or will not come to the school.

Regardless of how many steps are taken to minimize the impact of a child abuse report, the child almost always regrets saying anything, particularly if the abuser is someone the child loves or depends on. The clinician must be sensitive to the child's predicament and avoid using false reassurances such as, "Everything will be all right now."

The Legal System

Probably one of the most disheartening aspects of therapy with abused children is the unpredictability and length of

certain legal procedures. If the child must testify, this process can feel endless to the professionals—to say nothing of the children themselves. There are frequent continuances, and even when the child is required to testify, busy calendars or other external factors can require the child to return again and again before he/she is actually put on the stand.

Clinicians are sometimes criticized by defense attorneys for "preparing" a child to testify. A child's testimony can be discredited if she/he states that the testimony has been discussed with a therapist beforehand. Because of this, I suggest that the content of the child's testimony not be discussed during therapy sessions. The clinician can be helpful, however, in preparing the child to go to court. Caruso (1986) developed a set of pictures depicting a courtroom, the judge, the waiting room, and where the child sits. These pictures can familiarize the child with the courtroom ambience. In particular, the child should have some concrete idea of where she/he will sit to testify and of the distance from the offender; it is helpful if children who will testify know that they will be face-to-face with the offender, will likely be asked to identify the person, and can look at their own attorney or anywhere else if looking at the offender feels awkward or disturbing.

Court-Mandated Evaluations. A child's treatment is customarily suspended when the court requests an "independent" evaluation and is resumed once the evaluation is completed. The child's therapist and the evaluator prepare the child for the evaluation process, clearly explaining the projected length. Suspending the child's treatment sessions during the evaluation process may maximize the evaluator's potential to obtain important information from the child. There are circumstances in which suspending treatment might be contraindicated.

Report Writing. Working with abused children and their families can often be accompanied by nagging subpoenas for records. It has become my practice to write brief, matter-of-fact notes limited to issues of concern regarding the protection of the child. It is also my practice to always make every

effort to protect my client's confidentiality, making phone calls to my attorney in attempts to "block" subpoenas while remaining fully cooperative.

Testifying. Yet another customary adjunct in the therapy of abused children is the possibility of the clinician's having to give depositions or testify in court. These are always distracting and stressful, no matter how well accustomed the clinician becomes to them. Recent information, indispensable to clinicians who serve as expert witnesses or provide other testimony in court, has become available (Myers et al., 1989). I advise the clinician to secure an attorney well versed in issues of family custody.

Advocacy Efforts. Finally, working with abused children may precipitate a number of concerns regarding the social service and legal system and how it operates. Some clinicians find it worthwhile to channel some of their concerns into letters to the legislature, participation in statewide organizations dedicated to these issues, or membership in local child abuse councils.

Working with abused children and their families is challenging, stressful, and quite an opportunity. There are a number of obstacles, and planning ahead will prevent many of the typical problems associated with this work such as not knowing what's expected, getting involved in interagency conflicts, learning suddenly that new workers have been assigned to the case, and feeling helpless and futile. The clinician will be most successful working as part of a team, talking with other professionals on a regular basis, asking for guidelines in writing, and meeting periodically to discuss the status of the case.

APPLICATION OF ESTABLISHED CHILD THERAPIES TO WORK WITH ABUSED CHILDREN

At no other time in history has the child therapy field had such a rich array of therapeutic tools and props for therapists

to use. This is likely in response to the increase in childhood problems (such as drug abuse, delinquency, child abuse, suicide, youth prostitution) and a greater awareness within the mental health profession and the general public of the need for and efficacy of therapy for childhood problems. Clinicians currently working with abused children are in the enviable position of being able to draw from a growing literature reflecting many professionals' ground breaking and dedicated work. This cumulative knowledge helps us design more sensitive and effective treatment programs.

Some of the established child therapies are applicable to the therapy of abused children. These children have challenged mental health professionals with an array of unique behaviors that command a specialized response. The interventions are not offered as rigid, inflexible, or final in any way. The field of play therapy in general, and play therapy with abused children specifically, is in evolution; as more and more clinicians become trained and experienced and as research findings shape our understanding and thinking, more directives will be available about effective therapeutic strategies. The truth is that currently there are very few "rules" about this type of treatment, and we must equip ourselves with as much knowledge and experience as possible.

THE TREATMENT PLAN

As mentioned earlier, abused children are referred to treatment with an assortment of clinical symptoms that manifest underlying issues. The fundamental goal of therapy is to provide *corrective* and *reparative* experiences for the child. A corrective approach provides the child with the experience of safe and appropriate interactions that engender a sense of safety, trust, and well-being. In other words, there is an attempt to demonstrate to the child through therapeutic intervention the potentially rewarding nature of human interaction. A reparative approach is designed to allow the child to process the traumatic event in such a way that it can be consciously understood and tolerated. The healing power

of play cannot be underestimated; likewise, the survival instinct of humans cannot be underrated. If given a nurturing, safe environment, the child will inevitably gravitate toward the reparative experience. Even in the unfortunate situation where children are kept in actively abusive homes, or returned prematurely after temporary foster care, the reparative clinical experience tends to be stored and remembered, later serving as a motivating factor. Of course, the impact of the reparative experience will depend on many external factors, such as the degree of continuity in the therapeutic setting, how well parents or caretakers cooperate, and how rigorous the efforts of social service agencies and courts are in planning for the child's future.

When a treatment plan is being designed for an abused child, the presenting symptoms must not be considered in isolation. Beginning efforts are appropriately directed toward the reduction of the child's symptoms, but therapeutic efforts must persist long after the relief of symptomatology. Too many children are terminated hastily by relieved parents or shortsighted clinicians.

As stated previously, each child is unique and treatment plans will vary according to the child's needs, level of damage, ongoing response to therapy, and accessibility. In the following pages I discuss various treatment areas and include specific therapeutic suggestions for each area.

Relationship Therapy

Because abuse is interactional and usually occurs within the framework of a family, the child can profit from an opportunity to experience a safe, appropriate, and rewarding interaction with a trusted other.

Children entering treatment are curious, reticent, and often anxious or afraid. Physically or sexually abused children, or children who have witnessed domestic violence, have a background that can predispose them to feeling vulnerable. They have learned that the world is unsafe and have met the challenge by cultivating such defensive mechanisms as hypervigilance or extreme compliance. The neglected child, conversely, may show little resistance to coming to

therapy and may appear uninterested in and unaffected by the new surroundings. The neglected child is accustomed to inattention and has probably lacked even the most basic stimulation; he/she may sit still, expecting little. It is important in these cases for the clinician to underwhelm the child, then gradually introduce more stimulation. For example, sitting next to the child, facing away, coloring, or playing with some objects may be a good beginning; then, commenting on what is being done, directing the child's attention to toys, and, eventually, facing the child, asking questions, and encouraging the child's participation in a simple task like coloring will be effective.

The clinician always proceeds with caution, gingerly laying a foundation that advances a sense of security. (I have often imagined this step as the creating of a kind of sanctuary: quiet, accepting, stable, consistent, and free of external conflict.) One of the ways to create a sense of safety is to have a stable structure so the child can rely on certain aspects being constant.

Structure means many things. The length of the session, the location, the toys in the playroom, the "rules," the therapist's presence, and the procedure followed during the therapy hour are all features that can be used to build a strong structure. Even the way the therapist introduces himself/herself to the child is carefully designed. I have always found it best to be short and to the point in all communications with children:

> My name is Eliana. I am someone who talks and plays with children. Sometimes I talk to kids about their thoughts and feelings. Other times, I play whatever the child wants.

Regarding rules I say the following:

> There are lots of things you can do in here. You can play with anything you see. You can talk if you want. You can play or draw. You choose what to do. Sometimes I might ask you some questions. You can answer or not.

> There are a few rules. No hitting or breaking toys. No hurting yourself or me. All the toys stay here.
>
> We'll meet together for 50 minutes. I'll set this timer and when the bell goes off, it's time to stop until next time.
>
> Everything we talk about is private. I won't tell anybody what you say unless you are hurting yourself, hurting someone else, or someone is hurting you, including your parents or brothers or sisters. If that happens, I'll need to tell someone else so we can make sure you're OK, but I'll talk to you about it first.

Obviously, all these rules are not announced in the first session. In that session I usually introduce myself and give the general directives for what will happen. After that, I scatter the rules throughout the succeeding sessions.

The clinician focuses on the child's needs and provides the child with opportunities for self-exploration, adaptation, and new (functional) behaviors. The nondirective, client-centered therapies are most beneficial at the beginning of treatment. The child is respected and accepted. The child chooses what to do and what to talk about. The therapist observes (actively) and documents the child's behavior, affect, play themes, interactions, and so on. The therapist makes a great effort to earn the child's trust, responds honestly, does what is promised, and is present week after week.

The therapist must resist the temptation to overgratify or overstimulate the child; compliments and overattention must be curtailed. Factual statements are best. "You have new shoes on today" might be a more productive statement than "Your new shoes are beautiful." It's always better to inquire how children view something, as opposed to telling them how they feel. "How do you like your new shoes?" is more conducive to communication than "I bet you love your new shoes." These children may find it difficult to disagree with an adult's opinion.

Likewise, if questions are necessary (and sometimes they are), they must be phrased to avoid a yes/no response.

It can be difficult to make the transition to open-ended questions, but the results are most helpful to children. In addition, I have learned through trial and error the relative merits of using comments rather than questions—comments that invoke the child's interest. My favorite and most successful comment is "Humm, I wonder what that might be like...." or "I wonder what other feelings might be there...." Given the implied freedom to wonder along, children may freely offer their own thoughts.

Assuming the therapeutic structure is well received and the child begins to attend sessions more voluntarily—perhaps even looking forward to them—the child may discern positive regard from the clinician. Now the challenge commences, since abused children have frequently learned that intimacy implies threat.

One of the insidious lessons of physical, sexual, or emotional abuse is that "people who love you will hurt you." Neglected children learn that "people who love you abandon you." Either way, intimacy implies threat, and the child who feels reassured or consoled will inevitably feel endangered. Feeling in peril, the abused child may attempt to take flight emotionally, physically, or through some acting-out behavior. Understanding the child's need to flee or need to evoke an abusive response from the clinician provides direction for the clinician's serene and persistent responses. Green (1983) has postulated that the tendency of the child to provoke abuse may serve a need to "obtain otherwise unavailable physical contact and attention" (p. 92).

One memorable 6-year-old brought me a paddle four months into treatment. "What's this?" I asked. "It's a paddle," she said, surprised by the question. "What's it for?" I continued. "For you to hit me," she announced. I looked puzzled, stating, "Why would I want to hit you?" Her response was simple. "You like me, don't you?" It was as simple and as sad as that. She assumed that my regard for her would be followed by an attack. Rather than tolerate the anticipatory anxiety of waiting for the attack, she decided to take the initiative and provide me with my weapon. Needless to say, the next four months in therapy were quite a trial of wills.

She kept provoking and I continued to simply state, "I am not going to hit you, yell at you, or get mad. I'm going to show you that I care about you in different ways." I also said, "You would really feel much better if I hit you or screamed at you right now. But that is something that will not happen. I know that you expect grown-ups will hurt you, and I also know that you will learn that I will not hit or hurt you." The little girl needed to learn to tolerate the anxiety of expecting an attack. When I noticed her tension, I would say, "You're feeling worried that I might hurt you right now...it's OK to worry a little, until you know deep down that you'll be safe." Other times I would say, "I know you're worried, and it's OK to tell me when you feel that way. Sometimes, after you worry for a little while and nothing happens to you, the worry gets smaller and smaller." At the end of therapy she made me a little stitched purse and gave me a card saying, "Eliana. Thanks for liking me and not hitting me. Your friend always."

For neglected or needy children, the wish for attachment may loom strongly. These children make indiscriminate connections and seem desperate to be special to the therapist. They may ask point-blank, "Do you like me the best of all the children you see?" or "Do you miss me when I'm not here?" For them, intimacy is not encumbered with threatening feelings; it is an elusive sensation they long for. I respond to these questions by asking what they imagine I might feel and then commenting on how important being liked or missed is to them. If children persist I will say, "I do like you," "You are special," or "I think of you sometimes during the week" and then inquire what it's like for them to hear these things.

Setting limits for these children, by gently asserting the nature of the therapeutic relationship, is important. Not setting limits can be counterproductive for the child and his/her family. If the clinician becomes overly responsive to the child's needs or begins to behave in unusual ways (such as buying clothes and other presents for the child), the abusive or neglectful parent will be affected inadvertently. One therapist consulted with me when her 7-year-old client proclaimed, "I want you to be my mommy. I don't like my mommy as well as you." It is possible that a child could

develop this feeling without *any* encouragement, and yet I have frequently met well-meaning therapists who regret that they failed to keep clear boundaries in the therapeutic relationship with the child (and who confide that keeping clear boundaries is more difficult with children).

The psychodynamic concept of "transference" has applicability in work with abused children. Scharff and Scharff (1987) reviewing Freud's concept of transference, explain that Freud defined transference as "the repetition of a psychological experience from the past applied to the person of the physician: The physician is simply the present site for the distribution of the libido, or sexual energy, of the patient" (p. 203). Transference, therefore, refers to the relocation of thoughts and feelings about a primary person in the child's life to the clinician. The abused child is liable to experience emotions such as distrust, fear, rage, and longing toward the clinician. These feelings originate in the parental relationship and get transferred to a person who may feel safer to the child or who may require less caretaking or loyalty. As a result the therapist must refrain from behaving in any set way. Some therapists who work with abused children allow countertransference issues to dictate their behavior.

As alluded to earlier, abused children may become anxious and threatened by the unfamiliar (nonabusive) behavior of the clinician. These children feel helpless or bewildered by nonabusive behaviors, and in an effort to feel more in control and less anxious, they may become provocative.

During my first internship with abused children I, in my inexperience, brought with me, out of countertransference needs, an enormous desire to be nurturing. Many of the children literally attacked me, kicking my shins, punching my arms, and biting me. Green (1983) has suggested that the compulsion to repeat trauma and the identification with the aggressor "replace[s] fear and helplessness with feelings of omnipotence" (p. 9). This attacking behavior from children can evoke disturbing responses in the clinician. It was when I first confronted this behavior that I first acknowledged, as I have often shared in lectures, having hostile feelings toward children. I later came to recognize these angry feelings not as a sign that I needed to find a new career but as a sign that the children were provoking responses in me that were familiar to them in an effort to take care of their needs. Probably the greatest lesson I have learned from abused children and adults is that everything they do after they have been abused is designed to keep themselves feeling safe. This concept is beneficial in evaluating even the most difficult or irritating behavior. While early in the treatment I simply document the child's responses, and set limits when needed, once the therapeutic relationship is established, I make my observations explicit by describing to the child the connection between his/her behavior and underlying issues.

Nonintrusive Therapy

Because physical and sexual abuse are intrusive acts, the clinician's interventions should be nonintrusive, allowing the child ample physical and emotional space.

Physical and sexual abuse are intrusive acts that violate the child's boundaries. The body is hit or penetrated and the child feels "too much" of the parent. In these families abuse can be accompanied by emotional encroachment or detachment, either of which makes the abuse more complex. Abused children frequently have the experience of having extreme and unreasonable directives about what to think, what to feel, and what to do. The parents are either enmeshed with or disengaged from the child and may either restrict the child from any privacy or be totally apathetic. An abusive parent may sporadically want to take care of all the child's hygiene needs whereas a neglectful parent may fail to oversee any of the child's hygiene practices. Moreover, the behaviors of abusive and neglectful parents can fluctuate, particularly when drug or alcohol abuse is involved.

Because of these boundary problems the clinician's early interventions should be nonintrusive, allowing the child to set the boundaries. The child should be allowed to move around freely and choose desired activities. While the child plays, the therapist is advised to sit nearby, without hovering over the child's every movement. It is best to avoid a question and answer format and, instead, allow the child to communi-

cate spontaneously as desired. The clinician may obtain valuable information immediately. For example, some children may throw things, break things, wander in and out of the room, reset the timer, and generally test all of the regulations defiantly. Other children do the opposite: They sit quietly in a corner, avoiding interactions of any kind. They seem to recoil from the therapist, creating their needed seclusion; they are unresponsive and subdued. Sometimes these initial behaviors taper off after a while; at other times they linger beyond the expected period. All the child's behaviors are informative and purposeful. Both what the child does and what he/she fails to do furnish details of the child's inner world. If the child persists in a nonverbal mode or appears to feel pressured to perform verbally, the clinician may speak aloud, without addressing the child specifically. This technique is called "talking to the wall," and may allow a resistant child to listen in, and possibly respond. As the therapy proceeds it may be necessary to become more directive, particularly if the child continues to be avoidant or too guarded—especially about the abuse.

Some clinicians question what to do if the child avoids the topic of abuse in therapy. Often when I inquire into the details of the case, I find that the clinicians are relying on verbal validation of some kind. One clinician, who described the child's elaborate posttraumatic play, was frustrated that the child never made verbal reference to his abuse.

One of the errors in child therapy is observing the child passively rather than in an active mode. Active observation requires the therapist to participate in the child's play, not necessarily in a physical way but certainly in an emotional way. The therapist remains interested and involved, mentally logging the sequence of play, the themes, the conflicts and resolution, the child's affect, and the verbal commentary as it evolves.

The clinician must also refrain from inadvertently encouraging or permitting too much "random play," or play that has symbolic obstruction. A recent (and I hope short-lived) trend among therapists is to equip their offices with computer games: Children become absorbed in these games, but they are devoid of therapeutic usefulness. Therapists seem

to use these games the same way parents do: to entertain and/or relax the child. Less obvious, but equally worthless, is outfitting the therapy room with popular toys, such as converters and electric cars. These toys will summon specific types of play in children and do not lend themselves to symbolic reenactment of internal concerns.

If the child is making good use of therapy, his/her play will be sporadically significant to the clinician; it will almost always be enriching for the child.

Ongoing Assessment

Probably in no other kind of therapy is an ongoing assessment so necessary. Children may unfold during therapy, sharing their emotions and feelings as they begin to trust. They are also in a state of continuous developmental change with accompanying personality transfigurations.

Unlike that of an adult client, a child's personality is maturing during the course of treatment. A child is often "in the midst of rapid and continuous developmental and environmental changes" (Diamond, 1988, p. 43). As Chethik (1989) elucidates, "The child's personality is in a state of evolution and flux," with an immature ego, fragile defenses, easily stimulated anxiety, and often feelings of magic and omnipotence (p. 5). The child's ego is expanding; his/her consciousness and self-consciousness are developing; he/she is tentatively establishing identities; and he/she develops a repertoire of defenses and coping skills. Depending on the length of treatment, children's transformation can be immense as they tackle the pertinent developmental tasks. Children are influenced greatly by peers, and their behavior may change drastically under the influence of friends or teachers. As a result therapy strategies must sometimes change to address these differences: A child who is suddenly defiant and challenging may require firm limits; a child who begins to question his/her competence may require a focus on simple tasks that result in success; a child who suddenly becomes extroverted and inquisitive may benefit from a therapist who responds in an informative and directive manner.

However, any and all changes in the clinician's strategies must be well thought out and *purposeful.* I have frequently told students of child therapy that a clinician should be able to explain why she/he did what was done or said what was said—and why it was done or said at a particular moment. This can be more difficult with children who are less inhibited about their thoughts, actions, and behaviors and can act more impulsively. The clinician has less response time, which requires the ability to say, "I don't know," "Let me think about that a minute," or "I think I have two thoughts about that; let me take a second."

Effective assessments also require clear and measurable treatment plans based on active observations. Making a treatment plan with clear, concrete *behavioral objectives* allows the clinician a way to gauge progress. As I intimated earlier, one of the most common errors in working with children is an unfortunate tendency to ignore the child's play. Some clinicians seem lulled into passive participation in the therapy hour with children, perhaps because play can be self-absorbing for the child; many children require sparse interactions during their play. Greenspan (1981) maintains that active observation occurs on a variety of levels, involving the physical integrity of the child; the child's emotional tone; how the child relates to the clinician; the child's specific affects and anxieties; the way the child uses the environment; thematic development of the child's play (the way themes are developed in terms of depth, richness, organization, and sequence); and the therapist's subjective feelings about the child (p. 15). As Cooper and Wanerman (1977) suggest, "allow yourself a growing fascination with and respect for the minutiae of human behavior" (p. 107). The clinician who documents these levels of information is by necessity involved in the therapy as an observer–participant. Unless the therapist assumes this role, he/she is disengaged and is not conducting therapy to its fullest potential. If the therapist finds that the child is no longer using the play in a therapeutic way, or is engaged in stagnated or random and disorganized play, the therapist must intervene. However, if the therapist begins to think that the child's behavior is crystal-clear, the therapy warrants review. Cooper and Wanerman (1977) caution: "Slow down when you feel that you are beginning to understand the meaning of a child's play behavior" (p. 107).

Facilitative Efforts

Because abused, neglected, or emotionally abused children are frequently under- or overstimulated, they lack the ability to explore, experiment, and even play. The clinician must facilitate these natural, now constricted or disorganized tendencies.

Children who have been physically or sexually abused may be anxious, hypervigilant, dissociative, depressed, and/or developmentally delayed. They may be socially immature and may rely on the environment for performance cues. They may have had emotionally barren environments or emotionally chaotic and inconsistent ones. In either case their natural tendencies toward play may be interrupted, leading to anxious, disorganized, or chaotic play.

The clinician is advised to inquire about the child's common play patterns before meeting with the child. Parents, foster parents, day-care providers, or teachers may be able to provide information about attention span, play preferences, and other relevant issues. This knowledge is then used in selecting the type of playroom or play materials to be made available to the child. The chaotic, disorganized child will need a more restrictive setting with fewer options. The restriction can be accomplished by providing a large open space with previously selected toys or a smaller room with a limited number of toys to choose from. The worst possible combination for a child with disorganized, frenzied play is a large room with numerous toys and activities for selection.

The understimulated child will probably do the same in either setting. With this child, the clinician is, by necessity, more directive, selecting the toys and encouraging the child's interest and play. The therapist first attempts to encourage the child by modeling play behaviors, thus giving tacit permission for the child's participation. If the child continues to retreat from the play, the therapist can slowly encourage the child more directly. One of the major functions of play "is to alter the raw, overwhelming affects that arise in children at

times of anxiety and provide a natural vehicle for the expression of these affects" (Chethik, 1989, p. 14). A child's continued lack of involvement with play could signal a different kind of problem, and medical and neurological exams are indicated.

The selection of toys for play therapy is critical. Axline (1969) suggests a list of required materials, including the following:

> nursing bottles, a doll family, a doll house with furniture, toy soldiers and army equipment, toy animals, playhouse materials, including table, chairs, cot, doll, bed, stove, tin dishes, pans, spoons, doll clothes, clothesline, clothespins, and clothes basket, a didee doll, a large rag doll, puppets, a puppet screen, crayons, clay, finger paints, sand, water, toy guns, peg-pounding sets, wooden mallet, paper dolls, little cars, airplanes, a table, an easel, an enamel-top table for finger painting and clay work, toy telephone, shelves, basin, small broom, mop, rags, drawing paper, finger-painting paper, old newspapers, inexpensive cutting paper, pictures of people, houses, animals, and other objects, and empty berry baskets to smash. (p. 54)

Clearly, not all these items will be equally effective.

The doll house, family dolls, nursing bottles, puppets, and art materials are the necessary minimum.

In working with abused children, I have found the following toys or techniques to be repeatedly successful in encouraging the child's verbal or play communication:

- Telephones
- Sunglasses
- Feeling cards (i.e., illustrations of faces expressing feelings)
- Therapeutic stories
- Mutual story-telling techniques
- Puppet play
- Sand play
- Nursing bottles and dishes and utensils
- Video therapy

Telephones connote intimate verbal communication to the child. I usually sit with my back to the child and mimic

the confidential tone used in a phone call. The child usually turns away through example, and a more private conversation can ensue.

Sunglasses are magical: Children believe that they become invisible once they put sunglasses on. Wearing them gives children a comfortable anonymity that can disinhibit their communications, particularly when they have been feeling embarrassed or reticent.

Therapeutic stories have been frequently used in child therapy in a convincing way. Because children's imagination and ability to identify is so powerful, they can easily enter a story, making unconscious connections to heroes, conflicts, and resolutions. Stories have been used to teach children some basic concepts and to encourage their interest through a familiar medium.

A wonderful book that offers therapeutic stories specifically for abused children was made available recently (Davis, 1990). The author, trained in Ericksonian hypnosis, found that the use of metaphors in therapy could directly engage the child's unconscious mind and facilitate lasting changes. Her stories, specifically designed for an array of child-related problems, are insightful and very effective, particularly with latency-age children and preadolescent youngsters (and in some instances younger children as well).

Gardner's (1971) Mutual Story-Telling Technique can also have good results, but it necessitates the creation of a story by the child. Some abused children have restricted creativity and are anxious about their performance, so this technique may be more successful later in therapy.

Puppet play has several benefits. The child creates a story but does so anonymously, so to speak, using specific characters to portray hidden conflicts or concerns. I find it especially useful to have a sheet the child can sit behind, so that she/he can conduct the play while hidden.

Sand play can be very evocative. Children tend to like the sand (maybe because it's reminiscent of beaches) and enjoy the tactile experience of molding and shaping it or simply letting it rain through their fingers. My impression is that some children use sand play as a way to feel nurtured or soothed; they feel calmed by the play. Other children

immediately produce intricate scenarios, abundant with symbolism. The play is in and of itself therapeutic and provides the child with ample opportunities for a reparative experience.

The use of videos in therapy is very worthwhile. Abused children may be reticent to disclose their worries, fears, or self-doubts. They often have impaired self-images and lack the insight or confidence to recognize or express themselves freely. Watching videos that discuss topics such as self-esteem, emotional abuse, secrets, drug abuse, or coping with feelings, can be extremely beneficial for children for two reasons. First, it gives them a little distance to consider personal issues they may otherwise avoid, and second, the issue is presented in the child's medium, story-telling, and has the potential to engage the child's interest. I believe the first step toward self-empathy is the ability to empathize with others; the child watching a character in a videotape has the option to identify with the character, empathizing with his/her plight. The information presented in the tape is then discussed between the clinician and the child. I have been most impressed with a series created by J. Gary Mitchell (MTI Productions, 1989) in which a character called "Super Puppy" guides children through a variety of important issues such as those mentioned previously.

It's worth noting that children with established play patterns find it essential to have toys available to them on a consistent basis. Toys must be protected and constancy maintained. Toys do not leave the playroom under any circumstances. In addition, the therapist must convey a sense of comfort with the child's use of the toys (I have met therapists who buy expensive or irreplaceable antiques for the playroom, creating a kind of museum.)

Expressive Efforts

Because abused children are frequently forced or threatened to keep the abuse secret, or somehow sense that the abuse cannot be disclosed, efforts must be made to invite and promote self-expression.

Sundry ways of stimulating expression must be undertaken. Art, sand play, storytelling, doll play are all useful attempts. However, a child who seems averse to overtly expressing himself/herself may require considerable effort.

One technique I've found fruitful is making the need and use of secrecy explicit. I mark a paper bag "Secrets" and play a game with the child in which, every now and then we each pull out one of the secrets written on folded pieces of paper. The child may choose to select another secret to read aloud. The child sees this as a game and has less resistance to disclosing scary or uncomfortable secrets.

Sometimes I draw cartoon figures, for example, of a small child and an adult placing an empty cloud above their heads the way cartoonists do. Then the child fills in what is being said.

Caruso's Projective Story-Telling Cards (1986) are also effective because they depict so many familiar situations for children who live in dysfunctional families. The characters are obviously experiencing conflict, danger, fear, or discomfort. Children have an opportunity to project their own worries or concerns into the characters in the drawing. The clinician learns about the child and responds to his/her concerns as the child's projected concerns become clear.

There are no strict rules about techniques that can be employed to encourage the child to reveal inner thoughts and feelings. The clinician must be as creative as possible, using whatever interest areas the child displays. Perhaps no other clinician contributed such a multitude of creative ideas as James (1989). The more numerous the techniques available, the better; abused children can be resistant to self-disclose for a variety of external and internal reasons.

My impression has been that many children have difficulty with the expression of anger. They are afraid of the emotion, probably because of their history. They need to see anger as a normal emotion that can be expressed constructively and safely, not just in inappropriate and dangerous ways.

Most abused children have resentments and feelings of anger; however, they frequently squelch these feelings to

stay safe. Providing them with permission to show anger can generate a variety of experimental behaviors, some safer than others. It is useful to model safe expressions of anger, setting the necessary limits.

If the child shows more of a certain type of feeling than others, the clinician must begin to inquire about the range, for example, by saying, "You are very good at showing your angry feelings. What do you do when you feel sad?" Sometimes feelings are shown through the body. Children may tense up, bite their lip, or even scratch themselves during specific discussions in the therapy. The child's posture can help the clinician determine which concerns need attention.

Abuse affects the child physically. In physical abuse there is a great deal of pain sustained by the child; the body will develop physiologic responses, including muscle tension, and evidence of anxiety, such as flinching. An abused child, living with erratic violence, can literally prepare the body for an attack by holding the body still and experiencing other signs of physical distress such as shallow breathing, increased heart rate, and flushing. In cases of sexual abuse the child's body has usually been penetrated, creating a feeling of vulnerability. The child's body feels unsafe, and the sexually abused child does not have a sense of physical control.

Finally, some emotionally abused and neglected children do not receive normal physical attention or affection, and since it has been clearly demonstrated that physical nurturing of a child is as important as alimentation, neglected children can feel confused or inundated by a fear of or wish for touching.

Because of the innate physical issues for abused children, helping parents and caretakers encourage the child's physical activity is vital. The child needs to engage in the most basic of physical movements; walking, climbing, and running can begin to give the child a sense of accomplishment and pride as well as a knowledge of his/her physical limitations. It is important to keep expectations to a minimum until the child begins to thrive, allowing him/her to experiment at an individual pace.

When the child appears to be more physically comfortable, less tense, and more prone toward physical activity, it

can be beneficial to enroll the child in some kind of team sport at school or through a park and recreation department. Participating in group activities can engender a sense of well-being and belonging.

In addition, the formerly abused child may find self-defense courses educational and worthwhile. The abused child who learns principles of self-defense may feel empowered and less threatened by the environment. Most of the self-defense classes do not teach violence; they teach self-protection and respect for others. There is a great deal of self-motivation and self-discipline involved in learning self-defense, and many children I've worked with have responded well to this instruction.

Although there are some sex differences regarding preference of activity (boys prefer self-defense, girls prefer dance or movement), children can be stimulated to develop other interests if the activity is normalized. For example, one boy who was in a group with two other boys who took dance classes, developed an interest in dance classes after meeting other boys who liked this activity.

Directive Efforts

Abused or traumatized children may also have a tendency to try to suppress frightening or painful memories or thoughts and in some cases may use denial and avoidance fully.

Suppression is a necessary defense that allows the individual to store intolerable material in the unconscious so that it no longer interferes with current functioning.

Eventually, the abused child will be served by being able to suppress or consciously inhibit a specific impulse, idea, or affect associated with the trauma, but traumatic memories are best suppressed after they have been processed and understood. When this is done the individual has fewer experiences with fragmentation or splitting and dissociation. It is the repressed, or unconsciously stored memories, that can leak out into consciousness through posttraumatic symptoms.

The child's first and most natural tendency will be to use the defense of denial or suppression; the family frequently

joins in to try to put the unpleasant or painful memory behind. Families can reorganize quickly after a trauma, taking care to avoid individuals or situations that can trigger the memory.

The therapist can help a child who is avoiding the processing of traumatic material by guiding him/her through a thorough, time-limited review of the traumatic event so that the event can be understood, felt, processed, and assimilated. It appears that no matter how long this process is postponed, eventually (for most people) the unconscious brings the event back to consciousness through symptoms of posttraumatic stress syndrome, including flashbacks, nightmares, auditory hallucinations, or behavioral reenactment.

There is growing evidence in the literature that many adult survivors have amnesia for the abuse for most of their lives. This indicates how powerful and effective the defense mechanisms can be. I believe we can give abused and traumatized children a real advantage if we stimulate their processing of the trauma. This does not mean that these children won't need different levels of explanation and reassurance as they become more cognitively and emotionally mature. It does mean that the foundation is set for future exploration.

Privacy

Because in-home physical and sexual abuse and neglect are family matters and children may feel loyal and protective of their parents, it is important to expect the child's reticence and to structure opportunities for him/her to divulge information at his/her own pace.

Some abused children are threatened by their families or caretakers to keep all family interactions to themselves. They are told that they or loved ones will be harmed. Some of the children I've worked with have had demonstrations of what will happen to them if they tell others about secret family situations. One child witnessed the murder of his dog. The parent threw the dog against a wall, and brutally crushed its head with a brick. This was the incident that precipitated the mother's taking flight with the child. The

child suffered greatly about this for a number of years; since the child's environment was so wanting, the child had formed a strong tie with his pet.

Even when children are spared overt threats, many of them sense the secrecy of family violence or sexual abuse. They may not feel able to talk about feelings associated with their abuse.

Privacy is very important for children; secrecy is not. Establishing privacy empowers; keeping secrets engenders feelings of helplessness. Children required to keep secrets (through internal or external pressures) feel burdened, and the secret takes on great importance for them, alienating them from others and limiting the number of comfortable interactions they can have.

A number of techniques to clarify the difference between privacy and secrecy can be employed. Sometimes an abused child is at the crossroads of making a disclosure about disturbing thoughts or feelings. I might ask the child who refuses to continue, "What will happen if you say more?" If the child says "I don't know," I will explore possible alternatives by having the child "guess" what might happen. More frequently, the child has a specific reason for not telling, and she/he might respond, "Daddy will be mad at me" or "Mommy told me if I told, bad things would happen." I usually make the following statement, "It's really hard to talk about things when we're afraid. What might make it feel safer to talk about how you feel?"

Some children prefer to tell a stuffed animal in the playroom. I may ask them to pick out the animal they'd like to tell, and they can whisper it to them. Once they've done that, I ask how it feels to get these feelings out. Most of the time the children feel good about talking; sometimes they seem indifferent. I also might ask the child to imagine what the stuffed animal might say to them about their secret.

I have on occasion brought out a tape recorder and left the child alone in the playroom to tape what she/he wants to say but can't. Children usually ask if I will listen to the tape, and I answer that the tape belongs to them and they can let me listen when they want. Every time I've done this, the child has wanted to play the tape back to me right away. I then have an

opportunity to comment about the secret. I might say something like "It must be hard to be alone with that secret" or "It must be hard to keep that just to yourself." I usually ask the child whom he/she might feel safer telling and continue to talk about the difficulties of keeping things to oneself.

Obviously, if the child's secret concerns an event such as physical abuse or sexual abuse, the reporting law may enter the picture. However, many of the secrets include situations that are burdensome to the child but not necessarily dangerous.

Posttraumatic Play

Because posttraumatic play often occurs in secret, the therapeutic environment must create a climate for this type of play. Once the play begins, it must be carefully monitored for alterations, and at some point interrupted with suitable interventions.

The traumatized child is often compelled to reenact the traumatic event in an effort to master it. This concept was first introduced by S. Freud as "repetition compulsion." As Terr (1990) has affirmed, the reenactments can take the form of behavioral manifestations as well as play dramatizations. A reenactment is usually the result of an unconscious compulsion that the child may not understand. Some children claim that no matter how much they try, they cannot stop thinking about the trauma and frequently feel as if it were "happening again." Others claim that they no longer remember anything about the traumatic event and stubbornly deny any and all feelings related to the event. Processing the trauma can be achieved in a variety of ways. Some children are more able to discuss their feelings and concerns and may ask disarming questions about their abuse.

Because play provides a medium for communication, some therapeutic play provides a mechanism for uncovering concerns and releasing pent-up feelings. Some children simply go about the task of doing what they need to do to feel better; they need little more than permission—and the props—to do so. When this happens the clinician can observe, document, and eventually comment on what transpires and answer the child's questions or concerns.

For other children—perhaps those who have been more harmed by the traumatic event—the clinician's direction and stimulation will be needed before the frightening or overwhelming feelings and sensations can be faced. In these cases, forming a solid therapeutic relationship precedes any gentle probing to assist the child in addressing intolerable emotions. The goal of this work is to allow the child eventually to process the traumatic event, give it appropriate and realistic meaning, and store it as a tolerable memory. It is unnecessary to force the child into endless work on the traumatic event, particularly when the child is not denying or avoiding but has now redirected psychic energy into developmental tasks.

The play of the traumatized child who reenacts is quite unique. The child ritualistically sets up the same panorama and acts out a series of sequential movements that result in the identical outcome. The posttraumatic play is very literal and devoid of apparent enjoyment or freedom of expression. The potential benefit of this play is that while the child is undergoing memories that are frightening or anxiety-provoking, she/he is going from a passive to an active stance, controlling the reenactment. In addition, the formerly overwhelming event is occurring while the child is in a controlled, safe environment. It is possible that the child gains a sense of mastery and empowerment from this type of play therapy. As Chethik (1989) says of a clinical example, "The repetitious play, the comments of the player–observer, and his own new solution helped him assimilate a past overpowering experience" (p. 61).

Posttraumatic play can remain fixed. Terr (1990) cautions that allowing a child to continue long-term posttraumatic play can be dangerous; the child may not release any anxiety, and may have feelings of terror and helplessness reinforced. For this reason, after observing that the posttraumatic play remains static for a period of time (eight to ten times), I attempt to intervene in the ritual play, in the following ways:

- Asking the child to make physical movement, such as standing up, moving arms, or taking deep breaths. Physical movement can free up emotional constriction.
- Making verbal statements about the child's posttraumatic play, suspending the self-absorption and rigidity of the play.
- Interrupting the sequence of play by asking the child to take a specific role, describing the perceptions and feelings of one of the players.
- Manipulating the dolls, moving them around, and asking the child to respond to "what would happen if..."
- Encouraging the child to differentiate between the traumatic event and current reality in terms of safety and what has been learned.
- Videotaping the posttraumatic play and watching the tape with the child, stopping it for discussion of what is observed.

The goal of interrupting posttraumatic play is to generate alternatives that might promote a sense of control, help the child express fragmented thoughts and feelings, and orient the child toward the future. It might take a number of interruptions before the child allows the intervention to change the posttraumatic play.

If the child is engaging in posttraumatic play at home and the parents or caretakers have noticed it, two possibilities exist: The clinician either makes a home visit and asks to witness the child's play directly or the clinician creates the posttraumatic scenario (as described by parents or caretakers) in the therapy hour. It is possible that the child dissociates during the posttraumatic play. Treatment strategies for dissociation (discussed later) must be implemented as well.

The child whose play is random, disorganized, and devoid of symbolism may need greater stimulation. If a child persists in failing to address the underlying issues naturally, the therapist, taking a directive position, must introduce the stimulus in the therapy. Several techniques can work. A puppet story told by the clinician in which the central character experiences the same trauma as the child may elicit a response. The child may empathize with the puppet's plight; empathy with others is a first step towards self-exploration and self-empathy.

Some attempts at desensitization may also work. One child I worked with was raped in a park, and yet she was unable to offer verbal or nonverbal communications regarding the trauma. Her silence was fueled by a fear that she had brought on the rape by going to the park when she should have gone directly home. The boys had told her she "wanted" to be raped, and she was very confused because she had indeed wanted to be noticed by the boys and had gone to the park to be seen by them after overhearing mention of their destination at school. I had the girl color a page in a coloring book that depicted a park; I created a park scene with dolls playing in a toy swing; I made a park in the sand. I drove by a number of parks and, finally, asked the girl to show me the park where she had been raped. We drove by it first, then sat in the car outside the park, then walked around the outside of the park, and finally walked inside. Once inside, when I stated that the boys were very wrong to rape her and hurt her, she cried almost instantly, saying repeatedly, "I was bad, I was bad." This session, and six or seven that followed, focused on the rape and the child's feelings of guilt and shame. Eventually, she understood that she had done nothing wrong and that wanting to be noticed by boys was perfectly natural. This child also benefited greatly by talking to another preteen who had also been a rape victim.

Allowing the child to simply reenact without any apparent resolution is, as Terr has noted, "dangerous." In addition, the repetition of a trauma without resolution will reinforce the child's sense of helplessness and lack of control. The clinician must take an active role in helping the child both enter and maneuver the play, a role of actively commenting, rearranging, or intruding upon the sequence of events the child portrays. Reexperiencing alone is not enough. The thoughts and feelings generated by the play must be acknowledged and discussed. In addition, the child needs a struc-

tured way of "debriefing" from the play once it has terminated. The clinician must take some time helping the child reestablish a more comfortable emotional level. Guided imagery or simple relaxation techniques may have positive results. Alerting the parents or caretakers to the difficult work of the therapy, and asking them to plan appropriate responses, is very important. During posttraumatic play the child may appear more hypervigilant, anxious, and experience sleeping or eating disorders.

The overall goal of this work must be kept in the forefront. As Scurfield (1985), describing his work with adult survivors of various traumas, suggests the final step in the stress recovery process is the integration of all aspects of the trauma experience, both positive and negative, with the survivor's notion of who he or she was before, during, and after the trauma experience. Sours (1980), describing child therapies, states that "child therapies in general, whether they are supportive or expressive psychotherapies, tend to rely on abreaction, clarification, manipulation, and the corrective emotional experience of the new object" (p. 273).

Treatment of Dissociation

Victims of trauma may experience dissociation. The clinician must assess for dissociation, and devise ways of addressing the dissociative process.

The DSM-III-R defines dissociation as "a disturbance or alteration in the normally integrative functions of identity, memory, or consciousness" (p. 269). Dissociation occurs along a continuum; everyone experiences dissociative episodes, such as highway hypnosis. Boredom, fatigue, or fear may facilitate dissociation; the individual enters a trance state that can last for brief or extensive periods of time. Sometimes during frightening situations, like an earthquake, individuals may have brief dissociative episodes, later being unable to remember specifically what happened, or how they got from one place to another.

At the most extreme end of the dissociative continuum is multiple personality disorder. Other less extensive forms

of dissociation include depersonalization, psychogenic amnesia, and fugue states. Depersonalization is very common among abuse victims. Children often describe "out of body" experiences, in which they feel as if they are floating on the ceiling. From that vantage point (while emotionally detached) they look down on themselves. The ability to dissociate allows the child to mentally escape the dangerous or threatening situation. At the same time, the child may become confused about his/her own identity, having trouble remembering what has occurred. Psychogenic amnesia, in fact, is a disturbance in memory. Many child and adult survivors are unable to remember specific events or periods of their lives. Fugue states occur when an individual takes physical flight, without conscious knowledge of how he/she got from one location to another.

Dissociation is linked to trauma, particularly when the traumatic situation is ongoing. The more chronic and severe the trauma, the greater the likelihood of extensive dissociation. Lindemann (1944) wrote that "walling off" awareness or memory of the traumatic event is a valuable defense as long as the threat persists. However, as I've mentioned previously, clinicians who work with trauma survivors believe that the trauma must eventually be brought into awareness and put into perspective, or the repressed memories will appear in the form of intrusive thoughts, nightmares, reenactments, or emotional problems.

In my experience, many clinicians observe dissociation in children but remain unsure about how to proceed. Over the years, I have developed the following specific techniques for addressing dissociation:

Develop a language. The first step in addressing dissociation is to develop a way to communicate about it. I ask children about dissociation by saying, "Everybody has times when they're doing something and suddenly they notice that they seem to have gone away in their mind. Like when you're on a long drive and you get bored and you start thinking about different things, and suddenly you got to where you were going and you're surprised. Does that ever happen to you?" The child usually responds positively to the descrip-

tion. I then ask what name they give this process. Children have many names for dissociation, including "spacing out," "getting little," "going inside," "fazing out," and others. Once dissociation is labelled, it can be discussed.

Assess patterns of use. The next step is to inquire when the child dissociates; I ask children to tell me about the last time it happened, or when they think it happens most. As their attention is focused on dissociation, children may notice when they are using this defense.

The clinician and child can review similarities between dissociative experiences. For example in one case, the child seemed to dissociate more when he was alone, and when he was reminded of his father.

Help determine dissociative sequencing. Everyone who uses dissociation as a coping strategy has his/her own unique ways of generating a dissociative response. I find it useful to ask the child to "pretend to dissociate," paying particular attention to the body, emotions, sensations, and thoughts. Once the child is pretending to dissociate, either in the therapy office or at home, I ask the child to notice: what happens to his/her body and what feelings or sensations are experienced; what kinds of feelings he/she has; and what statements he/she might say internally.

The clinician points out the sequence to the child, possibly writing the information on a piece of paper so that the child has a visual representation. This material becomes particularly helpful when the clinician helps the child identify times when he/she might want to choose an alternative response to dissociation. Using the sequence that has been developed with the child's help, the clinician encourages the child to pretend to dissociate, and then stop the dissociation process at different points.

Explain it as adaptive. I always describe dissociation as a helpful defense: "Sometimes when we have a situation that's scary, or when it's too hard to feel our feelings, we 'space out' for a while. It's a really nice thing to be able to do." At the same time, I want to convey a couple of other messages: There are other ways of coping, and the child will feel more in control if a choice can be made about when to dissociate and when to use other strategies.

Understand precipitants. Once the child discusses times when dissociation is a helpful defense, the clinician can document the issues that seem to elicit this flight response. With some children, it appears to be a singular issue such as sexual arousal, physical pain, anger, or longing. For other vulnerable children, the emotions that precipitate the dissociative response may be numerous.

Address the troublesome emotion. Once identified, the emotions or situations that are troublesome to the child must be addressed in the therapy. The child needs to learn coping strategies so that emotions are not avoided or repressed.

One initial technique I've found useful is to externalize the specific emotion. For example, I'll ask the child to draw a picture of anger. Then looking at the picture, I'll ask the child to put words to the picture, and, finally, I'll give the child some open-ended statements such as, "I feel angry when..." "I feel angry because...." "I'm the angriest at..." As the child tolerates the discussion, the frightening emotion is desensitized. On one occasion a child drew a picture of fear, and when I asked what she wanted to do with her picture of fear, she crumpled it up, put it in a wastebasket, and covered the wastebasket with a bunch of pillows. This was her way of symbolically containing her fear, and over the weeks she removed more and more of the pillows until the crumpled-up piece of paper was visible. At that point she grabbed it, announcing "this is little now." She then threw it in the big garbage can outside my office. It was no longer an overwhelming emotion to her. She had learned to tolerate her uncomfortable feelings by talking to me and her father whenever she was worried or scared.

Give alternatives to the flight response. Once the feelings are identified, and the child tolerates open discussion, alternatives can be articulated. "What can you do when you feel sad?" I inquire, always asking for more than one option. "And what else can you do?" I ask after the child responds. If the child runs out of options, the clinician can volunteer other helpful information by role-modeling, "When I feel sad, sometimes I do or say...." I may also mention "Some children I've worked with tell me they feel lots of different ways, and one of those ways is...." It's important to be in contact with the

child's caretakers to assure they will respond accordingly to the child.

To summarize, dissociation is an adaptive and useful strategy to defend against frightening memories, sensations, or thoughts that occur in perceived threatening situations. While dissociation is a valuable technique that allows the child to escape immediately when threatened, it can later be a reflexive response that perpetuates feelings of helplessness and continued avoidance of reality. In addition, dissociation can interfere with the child's potential to develop a repertoire of necessary coping behaviors.

The clinician must evaluate the child's use of dissociation, developing techniques for discussing dissociation, making the sequence of dissociation clear, establishing the common patterns of use, and determining common feelings or sensations that precipitate dissociation. *The goal of treatment with dissociation is to help the child feel in control of choosing when he/she dissociates, and knowing the alternatives to dissociation.*

Transfer of Learning

The abused child may grow to trust the therapist and environment sufficiently to experiment with new behaviors. However, unless the child can transfer the behaviors, or discern which behaviors are transferable, the new knowledge can actually become counterproductive.

In working with abused children it is an error to reinforce behaviors that may precipitate attacks at home. For example, one child client was encouraged to ask questions and say how he felt in therapy. The clinician failed to alert the child that the new behavior could be received differently in different settings. When the child was reunited with his natural family, his mother, threatened by her perceived inability to provide information, would slap him each time he asked a question. It was months before a teacher filed a child abuse report and the child could be protected anew.

The therapist needs to help the child understand that some behaviors may provoke different responses in different settings. For example, when working with an abused child who is learning to talk about feelings, the clinician might ask, "How will it be if you tell your mom and dad how you feel?" or "What do you think they will say or do?" It is necessary to keep stressing, "It's OK to tell me about your feelings. Who else can you tell your feelings to?" Eventually, all children learn that people will respond to them differently and adjust their behavior accordingly.

Prevention and Education

All abused children can benefit from learning skills to employ in difficult, frightening, or abusive situations. Allowing the child to anticipate and plan for crises is useful.

Before the child exits therapy, the clinician can spend some time, in an educational mode, teaching the child about child abuse and prevention. I concentrate on a couple of important points: First, that children can say no, try to run away, and get help if someone scares or bothers them and, second, that if anyone asks them to keep a secret that scares or confuses them, they need to tell someone. I always review the child's support system, making sure they understand whom they can contact when they need help. I also convey to the child that he/she never causes someone to abuse him/her and that the abuser always has problems and needs help.

Some of this education can be done in a group setting. If groups are not available, this educational phase can occur within the context of termination of therapy. While some educational programs talk to young children about being "safe, strong, and free," I prefer to use less abstract concepts. I talk to children about the things that make them powerful; since their physical limitations are painfully clear, I concentrate instead on the powers they all possess, including the power to use words, the power to keep or share their thoughts, the power to keep or share their feelings, and the power to keep or share secrets.

Most children, particularly boys, have a tendency to talk about physical power when asked to think what they would do in the future if someone hurt them or did not take good

care of them. The children say they will kick, punch, or kill the abuser. But the reality is that children can be easily overpowered, and even though they don't like to see themselves as helpless, the reality is that they are. Because of that, I tend to reinforce the abilities to think, to decide, to choose, to act, to talk, to tell. These are indeed children's powers and can sometimes help to prevent their victimization. Recognizing these powers enhances self-esteem and feelings of competence.

Finally, abused children are vulnerable to feelings of low self-esteem. I spend considerable time helping children identify their strengths, and I validate them consistently. By the time they leave therapy, my child clients should be using positive affirmations, and relying less on external validation. Children who leave therapy must also have some skills in decision making, impulse control, and anger release; hopefully, the children also know what to do when they feel sad or disappointed.

Clinical Examples