

Cultivating a Healing Environment in Play Therapy Using Neurobiologically Informed

Interventions:

Two Case Studies

Jennifer Boswell

University of Houston - Victoria

Yvonne Garza, Jeffrey M. Sullivan, & Ian Lertora

Sam Houston State University

Author Note

Jennifer Boswell, School of Education and Human Development, University of Houston-Victoria.

Yvonne Garza, Department of Educational Leadership and Counseling, Sam Houston State University.

Jeffrey M. Sullivan, Department of Educational Leadership and Counseling, Sam Houston State University.

Ian Lertora, Department of Educational Leadership and Counseling, Sam Houston State University.

Correspondence concerning this article should be directed to Jennifer Boswell, University of Houston-Victoria, School of Education and Human Development, University West, Suite 228 3007 North Ben Wilson Street Victoria, Texas, 77901. boswellj@uhv.edu

Abstract

In this article, the authors present a treatment protocol that utilizes both traditional child-centered play therapy as well as neurobiologically informed activities. Some researchers in neuroscience posit that trauma therapy should functionally target enhancing brain development at the region of the brain where development was arrested at the time of the trauma. An examination of two case studies is presented using both outcome and process data. Additionally, the clinicians' perspective of the treatment is discussed.

Keywords: case study, neurobiology, play therapy, trauma

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Psychological trauma is an affliction of the powerless. At the moment of trauma, the victim is rendered helpless by overwhelming force. When the force is that of nature, we speak of disasters. When the force is that of other human beings, we speak of atrocities. Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning. . . Traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptations to life. . . They confront human beings with the extremities of helplessness and terror, and evoke the responses of catastrophe. (Herman, 1992)

Literature Review

Revolutionary advances in the field of developmental neurobiology has peaked an interest in the community of helping professionals treating children who have experienced trauma (Badenoch, 2011). This innovative knowledge of trauma experience on the developing brain is forecasted to affect the practice of a worldwide community of clinicians who share a commitment to helping young victims of trauma (R. Gaskill, personal communication, March, 23, 2012).

One focus of trauma research has been on the disruptive effect of attachment styles when children of a young age experience trauma, attachment and/or relationship-based treatments are encouraged (Siegel, 1999). Additional works note the significant mental health disorders in adults, also termed trauma *sequelae*, which have been attributed to early life trauma. These are subsequently linked to severe mental health issues in adulthood (i.e., borderline, dissociative

disorders, etc.) (Chu, 2011; Felitti et al., 1998). Common treatment approaches have included cognitive and behavioral therapies. More recent research in the area of neuroscience reveals that children who have experienced trauma are in a heightened state of alert, which causes a disruption in the brain's ability to process cognitive information. Subsequently, cognitive, behavioral and/or traditional talk therapies used with adults are not considered best practice for young children (Badenoch, 2011; Gaskill & Perry, 2011). According to van der Kolk, (1996) trauma memories are redirected to a sensorimotor location and can only be accessed via affective and sensory means.

Play is one way for children to safely revisit the trauma experience, allowing them to restructure that sensory and affective experience (Gaskill & Perry, 2011). However, Gaskill and Perry (2011) posited that play may not be sufficient in the treatment of early childhood trauma, and that therapeutic sensory modalities prescribed to target the brain region affected by the trauma experience supersede current healing methods. They hypothesized that new innovations in this area will change the way clinicians practice. This approach comes with specific assumptions about which activities should occur in therapy.

Despite the current innovations, incorporating and translating the neurobiological principles into practice seems daunting for clinicians, particularly nondirective play therapists (Perry, 2009). We intend to explore advancements in childhood trauma research by investigating the use of these practices to guide future research. To illustrate trauma-informed practice, we present the cases of two children exhibiting trauma symptoms through the lens of two clinicians who are ultimately the instrument of the therapeutic process. During treatment, these clinicians integrated child-centered play therapy and neurobiologically informed activities. They share their experiences as clinicians in this process.

Trauma History Overview

Trauma treatment has undergone many changes and advancements in the past 20 years. According to Chu (2011) knowledge about the effects of trauma has gone through three distinct phases; he noted them as first, second, and third generation models of treating trauma. A significant amount of research has been dedicated to understanding trauma experiences in children and how they affect development, personality, and a child's attachment to others. Currently, researchers are trying to gain knowledge about the effects of childhood trauma and how it relates to neurobiological development.

It was not until the early to mid-1980s that researchers in the mental health field began to understand the damaging effects of childhood trauma (Chu, 2011). At that time, it became clear that childhood maltreatment was linked to significant impairment and symptoms of Post-Traumatic Stress Disorder (PTSD). Yet, trauma research mainly focused on adults and combat veterans (Friedman, Keane, & Resick, 2007). While a description of the symptoms of trauma and PTSD were first introduced into the DSM-III in the mid-1980's (Foa, Keane, Friedman, & Cohen, 2009), there were few resources or treatment models to help children who had experienced trauma. Treatment models encouraged a client to verbally process unconscious thoughts and feelings as a way for providing symptom relief (Chu, 2011). Treatment was derived from a belief that the cortex, the part of the brain that controls judgment, could take executive control over emotional impulses, lending support for cognitive therapies.

In the second generation of the development of trauma treatment (the mid-1980s to early 1990s) the focus was on expanding training for practitioners who specialized in the treatment of trauma disorders (Chu, 2011). Symptoms of PTSD were refined in the DSM-IV which then led to a proliferation of research studies, as well as, assessments to identify PTSD (Friedman, Keane,

& Resick, 2007). In relation to the effects of childhood trauma, researchers discovered that prolonged traumatic experiences in childhood not only led to PTSD and dissociative disorders, but children also experienced difficulties in trust and relational capacity; affect regulation; impulse control; being able to manage separation from others and to self-soothe; and an inability to develop a positive self-image and a sense of self-efficacy (Chu, 2011).

In the third and most recent generation (mid-1990's to 2012) researchers are beginning to identify how childhood trauma affects neurobiological development; specifically, how successful brain development affects our ability to build healthy relationships and maintain emotional health (Foa, Keane, Friedman, & Cohen, 2009; Gaskill & Perry, 2011). According to Gaskill and Perry (2011), treatment approaches that do not consider the how the brain develops and is affected by trauma may not be the most viable modalities. Contrary to prior decades, researchers now have knowledge that the brain organizes from the bottom up indicating that in young children cognitive therapies target treatment to a part of the brain that is not yet fully developed (Gaskill & Perry, 2011; Perry, 2009). Additionally, in terms of treatment, Gaskill and Perry (2011) encourage “prescribing remedial interventions that match the child’s functional developmental stage . . . or lowest disorganized brain region” (p. 44).

Neurobiologically-Informed Practice (NIP)

Gaskill and Perry (2011) posited that key activities, when used in therapy, emulate remedial experiences that are “crucial to successful therapeutic reorganization of low brain functions” (p. 41). Gaskill and Perry suggested that a large part of success in child trauma work is using activities which target the region of the brain stunted at the time of the trauma. Because the children in our study were younger than four years of age, the regions most likely affected in development due to a trauma experience are the brainstem, or *diencephalon*. Dr. Bruce Perry is

trained in assessing children to match a therapeutic technique to the brain region affected, which is termed the Neurosequential Model of Therapeutics. For our case study, we offer a disclaimer that we have not received training in this model and offer ourselves as curious practitioners in NIT. We chose activities that focused on brainstem enhancement.

The brainstem is the lowest region of the brain and a region that is first to develop. Therefore primal, remedial, and seemingly nurturing brainstem enhancement activities are found in this protocol. These activities would include the therapist having a calming tone, rhythm and pitch and demonstrating an accepting facial expression and developing an intense positive climate. Additionally, primal activities such as rocking, feeding and other sensory infant games would be included in this protocol. Also these activities must be repeated, patterned experiences attending to the child's sensory modalities (Gaskill & Perry, 2011).

Play Therapy

Play therapy can be described as a counseling method that is used primarily with children ages three and older. It allows children to express themselves in the manner that is most comfortable to them, what play therapists consider the *language of play*. Young children often lack ability the verbal communication, introspectiveness, and skill in social interaction to express their selves in traditional talk-based therapeutic setting (Hull, 2011; Kottman, 2011). Thus, children's emotions can be verbally unreachable at times. However, children can show how they feels about their selves and the significant persons and events in their life through the manipulation of toys more adequately than through words (Ginott, 1994, p. 51).

Using play as a therapeutic medium provides children the space and opportunity to work through difficult issues in a safe environment. Play represents the attempt of children to organize their experiences and may be one of the few times in their life when they feel more in control

and thus more secure (Landreth, 2002, p. 11). The sense of security and control children receive within the therapeutic environment of the playroom gives them the necessary confidence, enabling them to go within themselves and use play to display their inner world. Through natural self-directed exploration, the *symbolic* language of play allows the child, to express, manage, and cope with emotions and reactions resulting from troubling situations, which, in *reality*, may be unmanageable for the child (Landreth, 2002). Hence, the play therapist creates for a child in the playroom, allowing the child to come to process their own understanding of experiences.

Child-Centered Play Therapy

Empowered by a desire to help children, Virginia Axline (1969) developed a nondirective play therapy approach using ideas and concepts from Rogers' (1951) client-centered therapy. Like client-centered therapists, child-centered play therapists (CCPT) believe that the structure of a person's personality contains three distinct interrelated parts that are (a) the person, (b) the phenomenological field and perspective, and (c) the sense of self (Landreth, 2002). The person is made up of constantly changing behaviors, thoughts, and feelings, and operates under the belief that people innately strive to move in a positive direction and towards self-actualization. The phenomenological field and perspective is essentially the totality of what clients have experienced in their lifetime, and it becomes the duty of the therapist to understand clients from their phenomenological perspective. A client's sense of self is regulated during childhood by the child's organismic valuing system, which attaches positive and negative significance to their different experiences (Rogers, 1951).

CCPT provides children with ample space and opportunity to work through their internal conflicting forces in a non-judgmental environment. The therapist operates under the belief that

children can work out their issues within the playroom with only minimal interference from the play therapist. The play therapist does not set specific and individual goals for children in play therapy. Instead, the general goal applied to all child clients is to create actualizing experiences that help the child move in actualizing directions and to develop towards their personal inner strength. By exhibiting unconditional positive regard, empathy, and genuineness, the play therapist remains active during play therapy and communicates a sincere interest in the feelings and experiences displayed by the child (Kottman, 2011).

Play Therapy and Trauma-Focused Therapy

CCPT has been used and researched across many settings, populations, and issues including trauma, and Kenney-Noziska (2008) postulated that play therapy is a viable approach for working with children who have experienced trauma. In a therapeutic environment, play itself emulates the primal process that children undergo developmentally, and play is not language dependent. However, while play therapy may be necessary in treating early childhood trauma but not sufficient (Gaskill & Perry, 2011). The brainstem and diencephalon levels of the brain are often compromised during early childhood trauma. While play therapy, especially CCPT, espouses a deep empathic relationship that matches the intense relational context prescribed by Gaskill and Perry (2011), they believe that the commingling of brainstem and diencephalon regulation activities are prescriptive and should include specific soothing activities beyond CCPT, with therapist-directed elements of appropriate skin-to-skin contact, grooming, and other relational and sensory stimulating activities.

CCPT & NIT Integration: Two Case Studies

We opted to present case studies because of the lack of research in the field regarding the integration of NIT and CCPT and to better inform future research. Essentially, we wanted to

pilot a model for CCPT/NIT integration to understand the experiences of those clinicians providing treatment and better understand the feasibility of such an integration of approaches. Our question here stemmed from the idea that child-centered play therapy is less structured than NIT. Clinicians adhering to CCPT believe strongly in the child to know best what he or she needs. Therefore, CCPT clinicians take a relatively non-directive stance and allow the child to take the lead in the session. NIT, on the other hand, is a clinician-directed approach, in which the clinician prescribes an activity to the child based upon the clinician's assessment of the child's needs. We were interested in seeing how well CCPT clinicians responded to integrating the more directive approach of NIT into their treatment protocol. All procedures used in these case studies were approved by the Institutional Review Board and pseudonyms were used when necessary to protect the identity of the clinicians and child clients.

Clients and Setting

Based upon parent and teacher reports, we carefully selected two children to participate in two sample cases exploring the integration of CCPT and NIT. The children selected met the following criteria: (a) their parent/guardian completed a consent form, (b) the child attended ten weeks of child-centered play therapy, (c) the child attended ten weeks of neurobiologically informed treatment (NIP), and (d) the parent/guardian completed at least two of the three assessments; and attended at least one parent consult. Teachers referred the children to treatment because they had experienced one or more types of traumatic events (Levine & Kline, 2007): child abuse, family violence, community violence, serious illness, parental divorce/death/separation, parental alcoholism, and/or surgery. Additionally, according to teacher report, the two children were exhibiting behaviors related to having experienced a past trauma,

which included: (a) hyper arousal, (b) dissociation, (c)constriction, (d) shutting down, and (e) outbursts.

The children received counseling once a week for 20 weeks in a preschool located in a southern part of the United States. The children were between the ages of 3 and 5 years old at the time of treatment. We de-identified play behaviors and themes that may reveal the identity of a child to protect the confidentiality of the child, but we also strove to remain true to the experiences of the child.

Therapist-Interns

Student interns with training and supervision in play therapy provided services to the two children presented in this article. Both interns were graduate students in a community-counseling program and at the internship phase of their program. The interns had received extensive training and supervision in play therapy (i.e., two semesters of graduate study in play therapy, a play therapy focused practicum, a-two semester field experience, and additional workshops). Each intern received weekly on-sight supervision during the course of treatment. At the completion of treatment, which lasted approximately 20 weeks, the interns wrote reflections regarding their experience of the treatment process. Along with the session notes, these reflections provided information on the child's progress, perception, and experiences of treatment. The interns also kept separate notes whenever supervision experiences related to these case two studies so those notes could be included here.

Treatment

Prior to treatment, each child's parent or guardian signed a consent form to participate in the treatment. The two clinicians also signed consent forms to discuss and share their experiences of the treatment with the authors. The interns held the treatment sessions in a

designated classroom room that the school made available for the purpose of play therapy.

Having a therapy space available where the children attended school meant that the children had good attendance in treatment, but also missed some class time as a result of their participation.

The room was free from distractions during the time that treatment took place. We took special care to design the room to keep the play therapy space separate from the space where NBIT occurred to protect the fidelity of each treatment modality. The school allotted 30-minutes for each treatment session, which the interns respected throughout the course of treatment.

Child-centered play therapy. The interns provided child centered play therapy (CCPT) twice weekly in 30-minute sessions for approximately ten weeks. The sessions were audiotaped to ensure the interns maintained the integrity of CCPT during their sessions. Their tapes were viewed weekly by a registered play therapist, who identified as child-centered.

The primary role of the interns included creating a safe environment that would allow the children to encounter trauma triggers through symbolic play and re-experience related emotions while feeling validated. According to the interns, this type of environment increased the children's trust in their own experiences. During all stages of therapy, the interns strove to provide the therapeutic conditions of warmth, genuineness, and unconditional positive regard in order to facilitate a safe and accepting environment (Landreth, 2012). The therapists endeavored to accurately perceive the children's subjective world and convey empathic understanding. The framework for empathic understanding was based upon the work of Carkhuff, who used a 1-5 rating scale to demonstrate counselor empathy, with 5 representing a high empathy response level from the counselor. Garza and Bruhn (2011) translated the Carkhuff levels for play therapists from different theoretical backgrounds, and the supervisors use this model to evaluate the responses of the interns, which were consistently rated at Carkhuff levels of 3 and 4.

Neurobiologically-informed practice (NIP). After the ten weeks of CCPT, the interns introduced a 10-minute NIP protocol that immediately followed the conclusion of the CCPT sessions. The procedures used for NIP followed the procedures described in Gaskill and Perry (2011) regarding the therapeutic enhancements for brain development of children who have experienced trauma. The interns transitioned with the participants by shortening the CCPT sessions by ten minutes in order to make time for the NIP activities while keeping the overall session length to thirty minutes. While practicing NIT, it was important to maintain the same therapeutic conditions and skills used during the CCPT. For example, when the intern introduced an NIP activity to the child, they would let the client choose the level of engagement with the intern. This way, the client felt some control, despite the intentional structure introduced by the intern at the NIP stage of the intervention. The therapeutic enhancement activities (NIP) were selected as follows:

Atmosphere. During the second 10 weeks of the study, it was our intention to focus on activities/rituals which facilitated nurturance and pacification. For this phase of treatment the child was escorted to a cushioned chair just outside the play space. The surroundings included a tri-fold cardboard display board covered in blue felt material with hanging white lights, creating a relaxing atmosphere with limited distractions (blocking their view of the toys in the play therapy space). In the background, soothing meditation music (designed for children) was playing. A teddy bear and squishy toy was available for the child to cuddle if they chose.

Touch. First, the intern introduced hand sanitizer or hand cream, and the intern used the following phrase: “We are going to use hand sanitizer, would you like for me to put some on you or would you like us to take turns putting some on each other?” This touching activity is a sensory modality designed to stimulate brainstem enhancement. According to Gaskill and Perry

(2011), touch was one of the most ancient remedies used for emotional healing and they posit that this practice helps return the traumatized child to a state of “*quiescence*” (p. 40).

Feeding. Next, the child was given a small cup with cheerios. The clinician would say to the child: “It is time for a snack. Do you want me to serve you, or would you like us to take turns serving each other?” This feeding activity is a sensory modality designed to stimulate brainstem enhancement. Gaskill and Perry (2011) suggested that the child and adult must genuinely want an emotional connection during this activity, and that in order for the desired neurobiological change to occur, this ritual should not be mechanistic.

Storytime. As the child ate their snack, the clinician read a book to the child, stating, “Now we are going to look at this book, would you like to turn the pages or should I?” We had a bookshelf with short picture storybooks and the child was allowed to choose one. This story time activity was designed to stimulate brainstem enhancement while arousing the senses. The part of this activity that stimulates the lower brain development is not the reading of the story itself. but rather the “tone, rhythm, and pitch” as well as “face-to-face gaze” (Gaskill & Perry, 2011 p. 42).

Smelling. When story time was over, the child was given a choice of using a scented spray. “I have some spray here if you would like some. Would you like me to spray some on you or should we spray some on each other?” This smelling activity is designed to target brainstem enhancement.

Ritual walk. As the child and clinician exited the room, the therapist would state: “Now we are going to walk back to your classroom, we will stay connected. You can choose how we do it. We can keep our thumbs or index fingers connected, or we can hold hands with one of us walking backwards like a train car pulling the other. How would you like for us to walk today?”

This *ritual* activity targets brainstem enhancement and indicates to the child that: “nothing has changed in our relationship; we are still connected.”

Case Study: Eduardo

Background

A 4-year old Mexican American male from an urban area of a large metropolitan city was referred to play therapy by his adopted parent because of his hyper-arousal, withdrawing from interactions with others in class and at home, and feelings of helplessness. His trauma history included: witnessing sexual violence, drug use, and experiencing physical and emotional abuse by his mother’s “*pimp*” (a term used by his guardian). According to his adoptive parents, Eduardo had difficulty being placed with external family members due to his severe behavioral and emotional problems. Eduardo’s teacher expressed concern with Eduardo biting other kids and becoming aggressive when he was overwhelmed in the classroom. Both the teacher and guardian also complained of his impulsivity at school and at home.

Intern’s Impressions of Treatment

CCPT. Ashlea noted that Eduardo’s play during CCPT was more like work than the typical play of a child. His play was rigid, lacked spontaneity, and appeared very deliberate. According to Ashlea, “It was almost as though he was afraid to let go and relax into his play.” Ashlea noticed that he “showed very little tolerance for uncertainty.” She experienced him as extremely apprehensive, and that he displayed themes reflecting a strong need for safety. His apprehension was so high that upon hearing noises in the room next door or hallway, he would become nervous and run out of the room, saying there was a monster nearby. He maintained this level of apprehension in session for several weeks. During treatment, Ashlea worked with Eduardo through his apprehension. She reported the following:

Over the next few sessions, he continued to act hyper-aroused and frozen when he heard the noises, so we walked next door so he could hear and see the source of the noise. He learned to check out the noise, acknowledge that ‘it’s just kid noises, not a monster,’ and return to the play room to continue our time together.

As the CCPT-only sessions continued, Eduardo’s play gradually shifted, revealing overt themes of power and control. Ashlea described this play, saying “he would often place me in compromising positions – handcuffed, legs tied, or sitting on the floor under a table telling me not to move.” Ashlea also remembered that Eduardo played out aggressive themes across sessions, including using the plastic knife to pretend to cut up not just the toy animals, but also Ashlea.

NIP. Ashlea reported that transitioning to NIP with Eduardo “allowed a greater glimpse into his life and behavior.” She reported that Eduardo began to reveal relationship themes in play sessions during the time period that NIP sessions were initiated. Ashlea remembered that “when he sat in the rocking chair, he seemed more like a kid to me – excited about cheerios, answering questions about the book, and even extending his hands for me to put lotion on them.” For Ashlea, “before NIP, he would never have held my hand to walk back to the classroom; more like he’d freak out about it. Now he initiates the holding activities and they seem to calm him.” Ashlea observed that Eduardo’s increase in relationship themes included connecting with her, demonstrating increased trust and feeling free enough to test limits during CCPT. During this time a shift took place in his play in which he allowed himself to become vulnerable and seek shelter from imaginary bad guys in fantasy play. Ashlea noted significant progress for Eduardo when he changed from being the perpetrator and needing a victim his play to taking on different roles. In this fantasy play, he now had the confidence to seek shelter rather than his

previous reaction of becoming frozen with fear. At the time of termination, Ashlea noticed that Eduardo was beginning to take more risks in CCPT by exploring his own competency through mastery play and working hard to build things using different toys. According to Ashlea, in his play during later sessions, Eduardo “started to expand on the theme of helplessness by rescuing toys whereas before the toy was almost always left abandoned.”

Intern’s Reflections

During the post-interview with Ashlea, she reported that “he worked so hard! He seemed to know just what he wanted to do in the play room and worked really hard every session.” She believed that Eduardo was able to eventually experience the safe and accepting atmosphere she strove to provide throughout treatment, and believed that “he was beginning to experience trust again.” Ashlea noted that he took considerable risks in therapy. In the end, she revealed, “I have hope that he will continue to risk trusting again, I saw him have several interactions with his classmates outside of the playroom and I could see the change in him.” When asked, do you believe the NIP protocol contributed to the positive changes you witnessed in your client? She stated, “Definitely.”

Progress and Non-treatment Factors

Eduardo’s caregiver reported to Ashlea that while Eduardo was in therapy she noticed him initiating more play with her at home, as well as increasing his frustration tolerance and desiring to connect more with his family. Eduardo’s teacher reported that he was more compliant with classroom rules and showed less impulsivity. However, both Eduardo’s caregiver and teacher acknowledged they were not sure how much of his progress was due to therapy versus the Adderall he was taking at the time of treatment. Still, according to Gaskill and Perry (2011), following this medication only treatment may control behavior, but would not

offer stimulation to a neglected neural system which could “atrophy and disappear...sadly, these changes can become permanent” (p. 35). Thus, while we cannot say that the improvement seen in Eduardo was solely because of the treatment or his relationship with the intern, that he showed improvement during the time he was experiencing this integration of CCPT and NIT should stimulate future research that may isolate treatment effects.

Case Study: Brayden

Background

Brayden is 4-year old Caucasian boy and the youngest of five children living with their stepdad and biological mother. According to Brayden’s mother, his contact with his biological father has diminished of late in large part because his father has a new wife and baby and no longer makes as much time to see Brayden. However, Brayden’s mother reported that he frequently asks to see his biological father; cries over feeling rejected; and has an increase in tantrums. Brayden’s mother described his biological father as an alcoholic prone to violent outbursts and physical violence. Brayden’s teacher, who referred him to treatment, reported that Brayden grows agitated easily in the classroom and acts out with violent behavior that includes kicking and hitting other students. However, Brayden can also be constricted and withdrawn, and can hold his feelings inside for a long time, but either way, his teacher reports that he is difficult to manage in the classroom.

Intern’s Impressions

CCPT. As play therapy began, Jean noted that Brayden included her very little in his play. She identified his play themes as being predominately *loss* and *grieving*. She also identified themes of *power, control, and aggression/vengeance*. As Brayden increasingly became

situated in the playroom, Jean noticed that he demonstrated aggressive themes where he remained in control. By the eighth or ninth session, Brayden's play shifted to reveal some *relational* themes that he initiated by having Jean engage in his play.

When reflecting on her sessions with Brayden, Jean commented, "There was so much going on at home he had a hard time dealing with it," and "I believe he moved through many different emotions and it was evident he had trouble communicating them in play. He couldn't get himself to remain in one play scene if it was intense." Jean did notice considerable improvements in Brayden by about the sixth session, adding that he "valued the time we spent in the play room and it was something he looked forward to." When reflecting on the progress she experienced with Brayden, Jean noted that Brayden seemed to benefit from "making better choices in certain situations at school with peers," and stated that "I also believe the relationship was therapeutic. It was a relationship he could count on." As the CCPT-only sessions continued, Brayden displayed a wide variety of themes in his play, including power and control, aggression, grief, and relationship. Brayden also displayed an increase in fantasy play that seemed to reflect the stress he was experiencing at home.

NIP. When Jean introduced the NIP stage of therapy, Brayden's play theme shifted back to relationship with her and he stopped his fantasy play about the new baby during his playtime. According to Jean, Brayden appeared to "value the time we spent together and was eager to come to play sessions." However, even though the counseling relationship was a strong theme for Brayden, Jean noticed that "elements of power and control began to emerge." At the time of termination, Jean observed that Brayden "seemed to withdraw a bit." She remarked that "it was obvious that he didn't want to say goodbye." When asked, do you believe the NIP protocol

contributed to the positive changes you witnessed in the client, she stated, “I liked it, I would like to learn more.”

Therapist’s Reflections

Jean began her reflection of her time with Brayden with a sigh, a long pause and a smile. She then stated, “He is a great kid, I think he felt rejected and unsure of how he was going to go about working things out. He still sees his father, but the relationship had all new rules and he had no say-so over them.” Jean discussed how Brayden’s relationship building at times seemed more important than playing. She added that when he did play, there seemed to be a hint of ambiguity and she used the skill of esteem building early on and consistently with him.

Progress and Nontreatment Factors

During a parent consultation that occurred five weeks into the NIT stage of treatment, Brayden’s mother reported that she caught him nearly choking a kitten to death. This event also occurred several weeks after his father had had a new baby with his new wife. At mid-point of treatment, the teacher indicated that while his aggressive behaviors had ceased, he seemed to display lots of helpless behaviors and relied on others to get him through activities. At time of termination, his teacher reported that, “we are having more good days, than bad days.”

Limitations

While our exploratory study met the constraints of our school setting, it was not the preferred protocol. Gaskill and Perry (2011), experts in this area, noted that NIP therapy (a) needs to occur more than once weekly, (b) should involve a variety of caregivers, (c) requires repetition of experience for the child to combat years of maltreatment and modify dysfunctional brain patterns. The researchers in this study are not trained in neurobiologically informed therapy (NIT), although they received supervision from a registered play therapist who identified

as child-centered and had received training in NIT. Still, the interns themselves were not experts in pairing the activity with the brain region affected. Therefore, we also do not attempt to make a claim for generalizability from these case studies. The focus of these two cases was to better understand the applicability of a treatment protocol that integrated CCPT and NIT to inform future research and practice, as well as better understand the responses of CCPT trained counseling interns when providing a more directive approach.

Implications for Practitioners

Advancements in the area of trauma research are evident. The emerging challenge for play therapy practitioners is how to incorporate new knowledge into current practice without throwing out the old in order to begin anew. It was our goal to co-mingle two expert modalities, expanding on our repertoire of what is possible in therapy for young children who have experienced trauma.

We were able to shed some light on the practicalities and complexities of integrating two treatment modalities, one relatively non-directive, one relatively directive. NIT is surprising congruent with CCPT and its focus on the empathic understanding communicated to and experienced by the client during treatment. Both approaches posit that relationship is the primary mover of client progress, yet NIT clinicians would likely assert that while the elements of CCPT are necessary, they are not sufficient. Nevertheless, many important new discoveries about the developing mind and its relationship to trauma suggest that it may finally be possible to understand, at a neurological level, what therapeutic factors are instrumental in client success when working through early childhood traumas. While these developments are still in the early stages, it is important for all therapists, including those trained in CCPT, to explore such developments with an open mind for the betterment of client outcomes. The reflections the two

interns from these case studies suggest that CCPT clinicians may be able to make room for neurobiologically-based treatments that preserve the integrity and primacy of the therapeutic relationship.

Moreover, these two cases further highlight the difficulty of ascribing therapeutic progress to any one therapeutic element. For instance, Eduardo seemed to show progress throughout the course of treatment, but he was taking Adderall during the time of treatment. Brayden experienced a setback in treatment in the time following the birth of his father's and step-mother's baby. Nevertheless, the progress indicated by the reports of the interns suggest the children were getting something from play therapy, and it will be up to future researchers to explore this more fully.

Finally, these case studies demonstrate how theory and research may be practically applied. Our hope is that practitioners, who are usually hesitant to conduct research, share their experiences by reporting case material (strengths and weaknesses) so that as a field we can grow for the common good of maltreated children. Wisdom and expertise is all around us; rather than practicing in isolation, we encourage literary discussion of experience and dialogue regarding practice and case discussion.

References

- Alexander, E. D. (1964). School centered play-therapy program. *Personnel & Guidance Journal*, 3(3), 256-261.

- Allen, F. H. (1934). Therapeutic work with children. *American Journal of Orthopsychiatry*, 4, 193-202.
- Axline, V. (1947). *Play therapy; The inner dynamics of childhood*. Oxford England: Houghton Mifflin.
- Badenoch, B. (2011). *The brain-savvy therapist's workbook: A companion to being a brain-wise therapist*. New York, NY: W. W. Norton & Company.
- Briere, J. (2005). *The Trauma Symptom Checklist for Young Children*. Odessa, FL: Psychological Assessment Resources, Inc.
- Chu, J. A. (2011). *Rebuilding shattered lives: Treating complex PTSD and dissociative disorders* (2nd ed.). Hoboken, NJ: Wiley and Sons.
- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventative Medicine*, 14 (4), 245–248.
- Foa, E. B., Keane, T. M., Friedman, M. J., & Cohen, J. A. (Eds.). (2009). *Effective treatments for PTSD: Practice guidelines from the international society for traumatic stress studies* (2nd ed.). New York, NY: Guilford Press.
- Friedman, M. J., Keane, T. M., & Resick, P. A. (Eds.). (2007). *Handbook of PTSD: Science and practice*. New York, NY: Guilford Press.
- Freud, A. (1946). *The psycho-analytic treatment of children*. London, England: Imago.
- Freud, S. (1909). *The case of "Little Hans" and the "Rat Man."* London, England: Hogarth Press.
- Garza, Y. & Bruhn, R. (2011). Empathy in play therapy: A case analysis through two

- theoretical perspectives. In D. J. Scapaletti (Ed.), *Psychology of Empathy* (pp. 167-184). New York, NY: Nova Publishers.
- Gaskill, R. L. & Perry, B. D. (2011). Child sexual abuse, traumatic experiences, and their impact on the developing brain, in handbook of child sexual abuse: Identification, assessment, and treatment (ed P. Goodyear-Brown), Hoboken, NJ: John Wiley & Sons, Inc.,. doi: 10.1002/9781118094822.ch2
- Ginott, H. (1994). *Group psychotherapy with children: The theory and practice of play therapy*. Northvale, NJ: Aronson.
- Hambidge, G. R. (1955). Structured play therapy. *American Journal of Orthopsychiatry*, 25,601-617.
- Herman, J. L. (1992), *Trauma and recovery: The aftermath of violence from domestic abuse to political terror*. New York, NY: Basic Books.
- Hug-Hellmuth, H. (1921). On the technique of child-analysis. *International Journal of Psycho-Analysis*, 2, 287-305.
- Hull, K. B. (2011). *Play therapy and Asperger's syndrome: Helping children and adolescents grow, connect, and heal through the art of play*. Lanham, MD: Jason Aronson.
- Klein, M. (1955). The psychoanalytic play technique. *American Journal of Orthopsychiatry*, 25(2), 223. doi:10.1111/j.1939-0025.1955.tb00131.x
- Kottman, T. (2011). *Play therapy: Basics and beyond* (2nd ed.). Alexandria, VA: American Counseling Association.
- Landreth, G. L., Jacquot, W. S., & Allen, L. (1969). A team approach to learning disabilities. *Journal of Learning Disabilities*, 2(2), 82-87. doi:10.1177/002221946900200203
- Landreth, G. L. (2002). *Play therapy: The art of the relationship* (2nd ed.). New York, NY:

Brunner-Routledge.

Landreth, G (2012). *Play therapy: The art of the relationship*. New York, NY: Routledge.

Levine, P. A. & Kline, M. (2007). *Trauma through a child's eyes: Awakening the ordinary miracle of healing*. Berkeley, CA: North Atlantic Books.

Levy, D. M. (1938). 'Release therapy' in young children. *Psychiatry: Journal for the study of interpersonal processes*, 1, 387-390.

Myrick, R. D., & Haldin, W. (1971). A study of play process in counseling. *Elementary School Guidance and Counseling*.

Nelson, R. C. (1966). Elementary school counseling with unstructured play media. *Personnel & Guidance Journal*, 45(1), 24-27.

Perry, B. (2009). Examining child maltreatment through a neurodevelopmental lens: Clinical applications of the neurosequential model of therapeutics. *Journal of Loss and Trauma* 14, 240-255. Doi: 10.1080/15325020903004350

Rogers, C. R. (1951). *Client-centered therapy: its current practice, implications, and theory*. Oxford, England: Houghton Mifflin.

Siegel, D. (1999). *The developing mind*. New York, NY: Guilford Press.

Taft, J. (1933). Thirty-one contacts with a seven year old boy as preparation for placement in a foster home. In J. Taft (Ed.), *The dynamics of therapy in a controlled relationship* (pp. 114-282). Oxford England: Macmillan. doi:10.1037/10602-003

van der Kolk, B. A. (1996). The complexity of adaptation to trauma: Self-regulation, stimulus discrimination, and characterological development. In B. A. van der Kolk, A. C. McFarlane & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp. 182-213). New York, NY: Guilford.