The Story of a Sexually Abused Child's Sandplay: A Single Case Study

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(ABSTRACT)

This single case study provides a detailed description of a 7-year-old sexually abused child's sandplay, describes prominent themes in the child's sandplay, and concurrent family transitions and events. Included are reflections and meanings that the therapist attributed to the sandplay. Child-centered play therapy was the guiding theory for the therapy.

Thirty-six consecutive therapy sessions are examined in this study. The therapy sessions were divided into three phases that were tied to significant life events and changes in the sandplay content and process, along with the therapist-child interactions were explored in each of the phases. There were many significant changes in the content and process of the child's play. He went from primarily using nonliving miniatures to using primarily living miniatures in his sand worlds. Specifically, the use of people and animals increased in his third phase sandplays. The categories of miniatures the child used also increased from one predominant category in the first phase to four or more miniature categories in the third phase. The child's sandplay moved from primarily static play to increasingly dynamic play. Changes in the child's play are linked to changes in his living environment.

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INTRODUCTION

"Children's play is not mere sport. It is full of meaning and import"

(Freobel, 1903, p. 22).

During my clinical training, I met and began working with a 7-year-old boy named David[1] who had been sexually abused by his biological father. Initially, I became intrigued by David because he did not talk with me during our therapy sessions, and he was fascinated with sandplay[2]. His sand work often consisted of using miniatures to make repetitive movements, which at first seemed to me devoid of meaning. David's capacity for repetition amazed me, since I had typically worked with children whose play constantly evolves throughout the session. However, as he continued to make sand worlds, themes began to emerge. David still did not speak very often, but he always appeared eager to enter the play therapy room and begin his sandplay work. While he worked in the sand, I assumed the role of observer or witness to his play.

Through the process of working with David, I became acquainted with his mother, older brother, two younger sisters, and the other mental health professionals providing services to this family. His father was serving prison time for sexually abusing David and his older brother. His mother was juggling the multiple demands of taking care of four children and working to provide for their basic needs, leaving her little energy to attend to their psychological needs. In fact, after I had seen David for about three months, David's older brother Mark disclosed to his therapist that he and David had been participating in sexual activities with each other and their younger sister. This

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[1] All names have been changed to protect the confidentiality of the participants.
[2] Sandplay is defined as "the playing out, or the making of, an emotional expression in a tray of either dry or wet sand measuring 281/2 inches by 191/2 inches by 2 to 4 inches deep" (Grubbs, 1994a, p. 193).

provided further evidence that David's mother was unable to provide a safe environment for the children. Thus, Child Protective Services (CPS) removed Mark and David from the home and placed them in foster homes.

As I gained a better understanding of David's family and the many events in their life, I began to wonder if David's family process and experiences were being reflected in his sandplay. Each time a new family event occurred, I noticed that the themes of David's play changed. For instance, David often used cars or dinosaurs in the sand and made repetitive movements with the miniatures; however, when he found out he was going into foster care, he made a sandplay with soldiers lined up on each side of the tray. David drew a distinct line in the middle of the tray to denote the two sides. In the battle he played out, the men on one side won (all standing up), while the other side lost (all lying down). Such graphic representations of real events in David's life led me to wonder whether family experiences are externalized through symbolic play.

BACKGROUND AND SIGNFICANCE

In the United States, it is estimated that one in three females and one in five males will be sexually abused before they turn eighteen (Whetsell-Mitchell, 1995). Johnston (1997) cites previous estimates that 15 to 45 percent of females and 3 to 31 percent of males are sexually abused. Regardless of the accuracy of the data, sexual abuse is highly underreported (Sadowski & Loesch as cited in Johnston, 1997). Surprisingly, only 10 to 15 percent of sexual abuse cases are committed by strangers. Therefore, at least 85 percent of the victims know the offender, while 25 percent of victims live in the same house as their abuser (Whetsell-Mitchell, 1995).

Sexual abuse encompasses both noncontact and contact acts. Whetsell-Mitchell (1995) lists noncontact sexually abusive behaviors as sexual comments, exhibitionism, voyeurism, and watching pornography, while contact sexually abusive behaviors include kissing, handling and fondling, fellatio or cunnilingus, vaginal or anal intercourse, frottage, and participating in pornography. Sexually abusive situations are characterized by a lack of consent and ambivalence on part of the victim, and exploitation, secrecy, force, and intent on the part of the abuser (Whetsell-Mitchell, 1995). In addition, the abuser has more power by virtue of his age, size, or gender, thus creating a power imbalance between the abuser and victim.

As a result of the high rate of child sexual abuse, the demand for mental health services for child abuse victims is increasing. Many mental health agencies have created units or programs devoted especially to the treatment of sexually abused children. Sexually abused children need specialized services because they are often unable to fully explain the impact of the sexual abuse in traditional talk therapy. Thus, clinicians often initially identify external behavioral symptoms that signify underlying emotional difficulties (Gil, 1991). Some of the most common symptoms that children who have experienced abuse exhibit include: emotional effects, such as guilt, shame, anxiety, fear, depression, and anger; physical effects, including psychosomatic complaints, injury, and pregnancy; cognitive and school-related problems; behavior effects, such as learned helplessness, aggressive and antisocial behaviors, withdrawal, self-destructive behaviors, and psychopathology; and interpersonal problems, including sexual problems and poor self-esteem (Lusk & Waterman, 1986). Furthermore, Browne and Finkelor (1986) report that the initial effects specific to the sexual abuse of children include fears, phobias,

depression, sleep disorders, eating disturbances, difficulties in school, anger, hostility, inappropriate sexual behavior, running away, and delinquency.

Although external signs of abuse are often identified first, the impact of the sexual abuse trauma manifests itself internally as well. Pynoos and Eth (1985) assume that a psychic trauma occurs "when an individual is exposed to an overwhelming event resulting in helplessness in the face of intolerable danger, anxiety, and instinctual arousal" (p. 38). Shengold (1979), who refers to sexual abuse as a "soul murder" (p. 533), believes that sexual abuse "has a lasting and profound effect…mobilizing certain defenses and structural changes, most of which tend to interfere with full, free emotional and intellectual development, and modifying the primal fantasies that motivate human behavior" (p. 534). Finkelor (1987) asserts that sexual abuse is "an experience that alters a child's cognitive orientation to the world and causes trauma by distorting the child's self-concept, worldview, or affective capacities" (p. 354).

The psychological trauma to the sexually abused child is often exacerbated by a variety of life disruptions. For instance, the child's parent may be removed from the home, the parent may be imprisoned (if the parent was the abuser), the child may testify in court, the child may be removed from the home (if the home is unsafe for the child), and the child may change schools (if the child moves to a foster home). As a result of these many changes, the child may feel unsafe and distrustful of people.

While there are many different approaches to treating sexually abused children, many experts agree that for young children play therapy is preferred, since play is children's natural way of communicating what they are experiencing (Axline, 1947; Gil, 1991; Landreth, 1993). Sandplay is one specific type of play that researchers and

therapists have found to be useful for children who have experienced sexual abuse. Grubbs (1994a) asserts that "sandplay gives the freedom and safety needed for [sexually abused children] to express this trauma since there are no rules or pressure to speak. It gives them a 'free and sheltered place' to express and resolve the dissociation, conflict, and pain which is the result of sexual abuse" (p. 195). Miller and Boe (1990) further add that sandplay "has been found particularly useful for traumatized children (Terr, 1983; Wheeler, 1987), and especially for abused children, who in such play are finally given the chance to be in charge" (p. 249).

While sandplay is the medium for therapy, the relationship between the child and the therapist must also be considered. Child-centered play therapy is one theoretical framework that honors the therapist-child relationship. One fundamental tenet of child-centered play therapy is that the child guides the therapeutic process. The therapist develops a warm relationship with the child without imposing a direction to the child's play, thereby encouraging the child's growth and development and respecting the play direction determined by the child (Axline, 1947; Landreth, 1991). Landreth (1991), a major proponent of child-centered play therapy, states that "the therapist does not solve problems for the child, explain behavior, interpret motivation or question intent, all of which would deprive the child of opportunities for self-discovery" (p. 98).

Although several studies document the effectiveness of using child-centered play therapy in general (Barlow, Strother, & Landreth, 1985; Bills, 1950; Kot, Landreth, & Giordano, 1998; Crow as cited in Landreth, 1993; Landreth, Homeyer, Glover, & Sweeny, 1996), only one study tests its effectiveness with sexually abused children. Zion (1999) conducted an outcome study examining the effects of individual child-centered

play therapy on sexually abused children's mood, self-concept, and social competence. In the study, 24 children, ages 3 to 9 years old, received 12 weekly play therapy sessions. There was no pretest to posttest improvement within the group; however, eight children demonstrated clinical improvement, four deteriorated, four improved with follow-up deterioration, and eight cases did not demonstrate any significant change.

In the absence of true outcome studies, case studies and descriptions often give some hint at the usefulness of a therapeutic approach. Child-centered play therapy case studies that do provide a description of how the therapy alleviated the child's distress often leave out the family context, the larger treatment system component, and the therapist's reflection upon the process. Luther (1994) integrated nondirective play therapy and the Metaframeworks Model (Breunlin, Schwartz, & Kune-Karrer, 1992) for family functioning and family therapy. This is the only case study I found that combined child-centered play therapy and the family systemic component. Darr (1994) is one of the few authors that includes the therapist's reflection upon the process in her case study, after describing the events that took place in the therapy session. However, in this descriptive case study Darr assumed the role of the researcher, thus giving her reflections a different perspective than if she was both the researcher and the therapist.

In order to address these gaps in the literature, I will discuss three issues in this chapter. I will provide a detailed description of a sexually abused child's play over the course of 10 months of therapy. I will also describe the prominent themes in the child's play and explore family transitions and events that occurred during the same time frame. Finally, I will offer my reflections of the therapy sessions, meanings I attributed to the play, and what I experienced during the therapy sessions. My reflections will be

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important because the child was primarily nonverbal during the sessions, and I do not know the meanings he attributed to his play.

CASE DESCRIPTION

Referral Information

David, a 7-year-old, and his older brother Mark, an 11-year-old, were referred to the community mental health agency where I completed my clinical training. They had both been sexually abused. The abuse was discovered when David and Mark's biological father was arrested for indecent exposure in the community and subsequently admitted to sexually abusing both children. Mark reported that his father showed him pornography, masturbated in front of him, fondled him, and attempted to anally penetrate him. David remained silent about what happened to him.

Mary, the boys' mother, came alone initially to the center for an intake session. During the intake, she described David as a quiet child who liked to be alone. Mary observed that after the sexual abuse was disclosed, David seemed even more quiet and withdrawn. David's teacher also commented to Mary that she noticed this shift in his affect and that he was less verbal and more subdued within the classroom. Furthermore, Mary expressed concern about the fact that David was watching her come out of the shower and was kissing his youngest sister on the lips.

After the intake was complete, both boys were assigned to separate therapists who began a nondirective developmental assessment with each child. The nondirective developmental assessments were conducted in play therapy rooms. As in child-centered play therapy, the child leads the process. For instance, some children may choose to talk, to talk and play, or just to play. The therapist observes the child's play, play themes,

affect, behaviors, verbal statements, and the family's interactions and draws diagnostic inferences from this data. The objectives of this process were to assess the boys' general developmental status, the presence of clinically significant symptomatology, the level of traumatic impact, and the family's functioning and ability to appropriately support the child's adjustment after being sexually abused. Based on the assessment, David was diagnosed with Post Traumatic Stress Disorder and individual therapy was recommended. I was assigned to be David's therapist.

David's entry into therapy did not flow smoothly. I was in contact with Mary for two months before she brought David in for his first appointment with me. During this time period, I spoke with Mary many times by phone and scheduled several sessions with David. However, Mary did not keep any of the appointments. When I spoke to her after a missed appointment, she usually said she had forgotten and once mentioned she felt depressed. In the meantime, an in-home worker was assigned to the family because Mary was having a difficult time bringing David and Mark to therapy and there was a high level of chaos at their home. The in-home worker often transported David to later therapy sessions. Subsequently, I met with David for 36 sessions of child-centered play therapy over the course of 10 months. David continued therapy afterward; therefore, this study does not represent the full course of David's therapy.

Family Background

During the time I worked with David, several important family events occurred. Three months after I began working with David, the children's babysitter observed Mark laying on top of his younger sister Michelle, a 3-year-old, simulating sexual intercourse, with their clothing on. Although he did not directly participate, David witnessed this

event. After the disclosure of this incident, a family meeting was held with Mary and all four children, the children's therapists, and the in-home worker. I participated in this meeting, but did not lead any of the conversations because I did not want David to see me in a directive role. In the meeting, the event was divulged and discussed, appropriate and inappropriate touching was reviewed, and rules for sleeping were established (each child was to sleep in a separate room and stay in their bed if they woke up, unless they went to get their mother). The in-home worker helped Mary establish separate sleeping spaces for each child in their small two-bedroom apartment; however, Mary had a difficult time enforcing the sleeping rules.

Two months after this incident, Mark shared with his therapist that he and David touched each other's genitals in bed at night. At this point, after much discussion between Mary, the children's therapists, the in-home worker, and the CPS worker, there was consensus that the boys needed to be separated and that they would be placed in foster care. Again, a family session was held with all family members, the children's therapists, and the in-home worker to discuss the foster care placement with the children. Mary told David and Mark that they would be going to live in foster homes and that she would still be able to have contact with them. Mark had many questions about moving to foster care; David, however, removed himself from the group, sat on the floor with his back toward his mom, and buried his face in his hands.

David was placed in a foster home with a woman named Karen, who spent a great deal of one-on-one time with David, reading to him, playing with him, and teaching him social skills and manners. David seemed to respond well to this adjustment. I often found him laughing and talking with Karen when I came to get him in the waiting room,

whereas before he was quiet and withdrawn. David also took to Karen's dog Buster and mentioned him frequently. Karen later told me that Buster was an abused dog she had adopted. Besides interacting with Karen and Buster, David made several friends at his new school and befriended an elderly neighbor.

Therapy with David

When I met David, he was a slim child, with pale skin, thick black hair, and big brown eyes. He often looked unkempt, wearing dirty clothes and smelling of sweat. He was typically quiet and withdrawn; he rarely spoke or made eye contact during our sessions. If I asked him a question or made an observation, David usually continued with the activity he was pursuing and did not respond or indicate that he heard me. However, there were occasions when David did make spontaneous comments and eye contact. After moving to foster care, I noticed that he would tell me "hi" more frequently and would sometimes initiate conversations.

Because David was nonverbal, withdrawn, a victim of sexual abuse, and his family environment was chaotic, I decided to use child-centered play therapy in working with him, since this would give him an opportunity to take the lead. I felt this was important because allowing David to make choices and direct his play differed from many of his family relationships where he had little power. In addition, I hoped to join with David through being present with him as he chose the activity for the session, and by paying close attention to his play and body language. I also wanted the play therapy room to be a safe and predictable place for David; therefore, we always used the same room, and the same toys and materials were present at each session.

The play therapy room David and I used had a dollhouse, puppets, dry and wet sandtrays with miniatures, art supplies (i.e. paints, markers, colored clay), dolls, therapeutic games (i.e. Talking, Feeling, and Doing game), blocks, and plastic kitchen supplies (i.e. cups, saucers). In sessions, David seemed primarily attracted to the dry sand tray and miniatures, and he completed one or more sandplays in 35 out of 36 of the sessions that form the basis for this case study. David did choose other activities during some of the sessions, such as paints, colored clay, a game, and blocks; however, he rarely spent more than 10 minutes pursuing those activities. In the session that David did not complete a sandplay, he used clay to make different objects and spelled words with alphabet letters.

David's sandplay had several distinct qualities. As David worked in the sand, he often appeared totally absorbed, sometimes to the point of seeming to be in a trance. His play often consisted of repetitive movements such as driving cars in a circle over and over. When I first began working with David, he would take one miniature off the shelf at a time and once he completed his sandplay, he would return all the miniatures to the place where he found them. As he continued in therapy, David began to leave the miniatures in the completed sandplay. Another unique quality of David's sandplay was that he constantly moved or played out scenes with the miniatures. He rarely just set a miniature in the tray without moving it around. Other children David's age often set the miniatures in the tray, to create a picture or story, without moving the miniatures around in the sand.

METHODS

To understand the complexity of the David's play and its relationship to the events in his life, I used several sources of data--my observations, session progress notes, photographs of the child's sandplay creations, journal of my reflections, and David's family background information and developmental history via forms that Mary completed. After reviewing the data, I divided the 38 therapy sessions with David into three phases. The first phase encompasses sessions 1 through 11, second phase-sessions 12 through 27, and third phase-sessions 28 through 38. My decision to divide the therapy sessions into phases was based on family events. In the first two phases, David lived with his biological mother and siblings, while in the third phase he lived with his foster mother. The second phase begins when Mark disclosed to his therapist that he had sexually acted out with his younger sister, which David witnessed. The third phase starts when David moved to his foster home. During the second phase of therapy, two of the sessions were family sessions. In one session David did not complete a sandplay; therefore, his sandplay content and process was examined in only 35 out of the 38 sessions. However, verbal and nonverbal interaction data was provided for all 36 sessions of individual therapy.

I examined three aspects of David's play—content, process, and interaction. Content refers to the type of miniatures (i.e. living and nonliving) and the number of miniatures used in the sandplay. In the process category, I looked at the overall process of making the tray and specific process-oriented behaviors within the tray. Process and content data were coded by looking back at progress notes where I recorded the miniatures used in each sandplay, the process of making the sandplay, family events, eye

contact, and verbal statements. I also used photographs of David's sandplays to determine the number of miniature categories within a tray.

The verbal and nonverbal interaction categories were the hardest to code. I first divided the sessions into three categories—withdrawn (no eye contact or verbal statements), minimally engaged (presence of either eye contact or verbal statements), and engaged (both eye contact and verbal statements). However, I was not sure these three categories most accurately portrayed my experience of David's interaction; therefore, I experimented with several different coding systems. In the end, I returned to the three original categories of data. Although I coded the interaction data many times, I still did not capture all of the involvement within this category. For instance, in some of the withdrawn sessions I felt connected to David and his play experience even though he did not initiate verbal or nonverbal contact with me. Nevertheless, the coding scheme allowed me to at least look at broad patterns of David's interaction with me during his therapy sessions.

DESCRIPTION OF DAVID'S SANDPLAY

In order to provide a clearer picture of David's play, I will describe a sandplay from each of the three phases. The sandplay described in phase one is typical of David's early posttraumatic sandplay, filled with constant repetition and use of one miniature category. Posttraumatic play occurs when the child's play is "compulsive, repetitive, unimaginative" (Jones, 1986, p. 379). During posttraumatic play, the child may be oblivious to any observers and appear "cut off from reality" (Allan & Lawton Speert, 1993, p. 34). Terr (as cited in Gil, 1991) adds that there is an unconscious link between the play and the traumatic event and that the play fails to relieve anxiety. The sandplay

described in phase two represents the increased aggression in David's play. Finally, the phase three sandplay represents the sadness and loss David expressed in the third stage.

Phase One Sandplay

In my first session with David, I told him that he could select any of the materials in the playroom to use. Since he had been to the playroom previously during the assessment phase of treatment, I asked him if he would like to show me around the room. He pointed to a few of the materials in the room and initially selected a game to play, then selected colored clay, and finally chose to use the dry sand tray and miniatures. As I watched David make his tray, I was mesmerized. He picked one car or truck from the miniature shelf at a time. He put the vehicle in the sand and drove it in a circle. He then went back to the shelf, selected another vehicle and moved that car in the same circular-like movement. This process continued until he used all of the car and truck miniatures in the playroom. David next placed all the vehicles in a circle in the middle of the tray and moved one car out of the circle at a time and made the same circular-like movement until all the cars had been moved once again. This process of moving the vehicles continued until the session was over. David then removed each vehicle one by one and put them back on the shelf. At the time, I was stunned by David's capacity for repetition and by the marked difference between his play and that of other children's. I had no way of knowing how much I would continue to be surprised and enlightened by his play.

David made the same repetitive movements with cars over and over again in subsequent sessions. In fact, he often spent the entire 50 minute session moving vehicles in a repetitive circle-like movements. While engaged in this play, David appeared cut off from reality and oblivious to my presence. He always stood in the same position as he

made the tray and had no verbal or nonverbal contact with me. Both the repetitious nature of David's play and his disengagement from me differed from the spontaneous, engaged quality of other children's play. To me, David's repetitious play appeared stuck. I also wondered if lining up the cars in the tray, and taking each miniature out of the tray individually and putting it back on the shelf in a particular place, were David's attempts to bring order into his life.

I often wondered about David's selection of cars, which he continued to use throughout each treatment phase. Modes of transportation are seen as being a developmentally appropriate selection for males David's age. Cockle (1993) suggests that children who frequently use transportation miniatures in their play may "experience a sense of movement and progression" (p. 13) by doing so. The Dictionary of Symbols states that cars are "vicissitudes of active psychological development" (Chevalier & Gheerbrant, 1994). David never verbalized the meaning he placed on the frequent use of cars in his sandplay. However, I began to embrace the idea that the cars' movement within the tray might represent David's own movement and growth. In the beginning therapy stages, the movement of the cars may have been preparation for David's later internal and external changes and transitions.

David's use of circles in phase one, and throughout his therapy, was interesting to me. Many of the movements within the car sandplays were circular. Furthermore, the marbles David often used in phase one sandplays were also circular. Kalff (1980) discusses the circle as a "symbol of perfection and of the perfect human being…a well known expression of heaven, sun, God and for the ideal of man and the soul" (p. 24). Circles also represent "wholeness" or a symbol of Self (Kalff, 1980). David use of

circles could be related to the desire to be whole again, since his sexual abuse experiences and his family experiences may have left him feeling wounded and vulnerable.

Phase 2 Sandplay

During the middle therapy phase, the repetitive play sequences were still prominent. David completed many sandplays with vehicles alone, but also began adding additional miniatures to the vehicle trays. Other trays David made during this phase told a story, rather than being repetitive and stagnant. In our 22nd session, a battle sandplay seemed to express David's inner turmoil during this stage (see Appendix H for a photograph of this sandplay). David first selected an army tank and drove the tank down the middle of the tray, dividing the tray into two sides. He then carefully selected a combination of soldiers, warriors, knights, Native Americans, and spacemen, all of whom were holding some type of weapon. He lined up the people facing each other on both sides of the tray.

Once the soldiers were arranged, David acted out three successive battle scenes. All of the battles involved people shooting and stabbing each other. David pointed the weapon toward a specific soldier and made an explosive noise as the person was being shot. If the soldier was carrying a knife or sword, David made a throwing motion with the weapon toward a soldier on the opposing side. After the person was shot or stabbed, David laid the person down. In the first battle scene, everyone on both sides was killed at the end of the battle. During the second battle scene, all the soldiers on one side were killed while the soldiers on the other side remained standing. In the last battle, some soldiers were killed on each side and some were left standing. After the final battle

scene, David put a rubber dragon puppet on his hand and destroyed the scene. He then used the army tank to run over certain soldiers repeatedly.

David made this sandplay six days after Mark told his therapist that he and David had been touching each others' genitals while in bed together. The family's CPS worker alerted me that she was considering removing both boys from the home and that she had discussed this with Mary. At this time, David had not been told about the possibility of moving to a foster home. However, I wondered if David was subconsciously aware of the impending changes in his family and if the battle represented his conflicting feelings about the family changes and his anger toward his brother for the disclosure of the abuse. As often seems true in play therapy, the battles may have represented his inner turmoil associated with the current family chaos. I found the different endings of the three battles particularly interesting. With each battle, David was able to come to a better resolution—from everyone dying to all of one side dying to some soldiers on each side dying. The last resolution seems inherently better than the first because some soldiers survive the battle. Playing out the battle scenes may have been helpful to David as he tried to reconcile his feelings about his current family situation and find some emotional resolution.

The miniatures that David selected for this sandplay were also intriguing to me. Soldiers are often used to represent aggression, anger, attacking, hurt, or destroying. Army tanks often symbolize a weapon, aggression, and destruction. Chevalier and Gheerbrant (1994) discuss the ends of warfare as symbolizing "destruction of evil and the restoration of peace, justice, and harmony" (p. 1078), which may account for David's resolve in changing the battle ending three times.

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Phase 3 Sandplay

As David walked in the room for our 35th session, his head was down and he

appeared to be sad. He immediately went to the sandtray and carefully selected a family

of six people (mom, dad, two older brothers, and two younger sisters) to add to the tray

(see Appendix I for a picture of this sandplay). He moved the people's legs in a manner

that made it look as if they were walking around the tray. After arranging the people, he

added a gravestone for each person and buried the person beside their gravestone a

couple of times, always being careful to cover the person's body fully with the sand.

David then selected an animal to put beside each family member and their gravestone.

For the father and oldest brother, he selected identical goat miniatures. He placed a

small horse beside the mother figure. The younger brother's animal was a black and

white polka dot puppy, while the two younger sisters were represented with a small pig

and a lamb. Next, David added a large family of wolves to the tray. The largest two

wolves were placed by the mother and father figures, and the smaller three wolves were

placed by the two boy figures and the smallest girl figure with the lamb. David looked on

the shelf, but wasn't able to find another wolf for the girl with the pig. The family

members were then buried again, with their animals. The wolves stood in front of the

graves, as if to guard them. David continued to bury the family in different places. Once

the entire family was buried together, except for the boy with the dog. The boy and dog

were buried in the opposite corner from the rest of the family. In the final placement of

miniatures, the family members' graves were spread out around the tray. Each person

was standing in front of a grave, with the animal beside them and the wolf in front of

them. David placed the boy and dog upon a hill, while the rest of the family members were on a flat surface.

As David made this sandplay, the room felt heavy and sad to me, almost as if I was witnessing a real-life burial. Once David selected the gravestones from the shelf, my thoughts drifted to the comment he made to his foster mother the week before about his father being dead. In reality, David's father was not dead, but in prison. I also became interested as David selected the family miniatures. Six family member miniatures were selected, just as David has six members in his own nuclear family. The miniatures included three female figures and three male figures, similar in size to the three males and three females in his family. As he continued to make the tray, David added an animal figure beside each person. I wondered if each animal was a representation of the person.

David did not verbalize his meanings, so the descriptors I present are only possible associations David may have made between the family member and the animal. According to Chevalier and Gheerbant (1994), goats are associated with "life force, libido, fertility, tragedy, sin, disobedience, uncleanliness, lust, obsessed by sex drive, smelly, and wicked" (p. 435-437). The goats were placed beside the dad and older brother figure, the people who abused David in his family. The small horse figure was placed beside the mother figure in David's tray. Horses symbolize the "mysterious child of darkness and light, destructive yet triumphant powers of Fire to the nurturing yet suffocating powers of water, mother-figure, sexuality, and lunar powers" (Chevalier & Gheerbant, 1994, p. 516-526). From the descriptors, it appears that the horse is a contradictory figure. David's experience of ambivalence about his mother may have kept him guessing whether she would be emotionally and physically available and would

provide a safe environment for him. The second boy in the family had a puppy dog beside him. Dogs are described as a "companion, guide, master, hero, and protector" (Chevalier & Gheerbant, 1994, p. 296-302). The dog may have represented David himself. If so, it seems as if the object represented a healthy view of self. Furthermore, it was interesting that David is very connected with Buster, his foster mother's dog, and that both he and the dog shared the similar experience of being abused. The oldest sister in the family is placed beside a small pig. Pigs are associated with "gluttony, greed, insatiability, ignorance, lust, and selfishness" (Chevalier & Gheerbrant, 1994, p. 753). Pigs in fairy tales, such as The Three Little Pigs, have been portrayed as vulnerable prey. I did not have a clear idea about how the pig represented this sister; however, it was interesting that this sister received more attention from Mary and had been subject to Mark's sexual reactivity. The youngest sister, age one, had a lamb beside her in the sandplay. Lambs are associated with "spotless, white, renewal, sacrifice, and innocence" (Chevalier & Gheerbrant, 1994, p. 585). David may view his baby sister as being innocent and not understanding the family situation. He could also see her as the one in the family who was not abused. Wolves are described as "light, sun, warrior, hero, protector, threaten, and conductor of souls" (Chevalier & Gheerbrant, 1994, p. 1119-1121). The wolves around the family and their gravestones could symbolize protection.

Burying the family could have several meanings. One possible meaning is that David was burying his past and needed to symbolically bury his family in order to move on. David could also have been emotionally burying the painful memories associated with some of his family experiences (i.e. being sexually abused) by burying family members in the sand tray. The burial act could also represent David's full transition to

his new foster mother and home and signify his growth as he was able to make the transition successfully. Burying each person separately could signify the emotional and physical distance between the family members. David's burial of himself separate from the rest of the family could symbolize the separateness he felt from the rest of the family and the associated feelings of loneliness.

PLAY THEMES

As discussed earlier, I looked at three aspects of David's play—content, process, and interaction. Content refers to the type of miniatures David used within the sandplay and the number of miniature categories. In the process category, I classified each tray as either static or dynamic and determined prominent process-oriented behaviors within the sandplays. The interaction category focuses on the level of verbal and nonverbal between David and I in each session.

Sandplay Content

The content of David's sandplay changed throughout the three phases. To better understand the type of miniatures David used in each phase, I divided the trays into two categories--living and nonliving (see Figure 1). I decided to divide trays into the living and nonliving categories because sandplay research suggests that the increase in living miniatures in a child's sandplay connotes an increase in the child's internal and external resources (Bowyer, 1970; Cockle, 1993). I used Khan's (1994) categories of living miniatures, which includes humans, animals, and vegetation, and nonliving miniatures, including buildings, vehicles, construction, natural objects, and man-made objects. If David used one or more living miniatures in the tray, I classified it as living. If he used only nonliving miniatures, I classified the tray as nonliving.

Figure 1
Sandplays with Nonliving & Living Miniatures
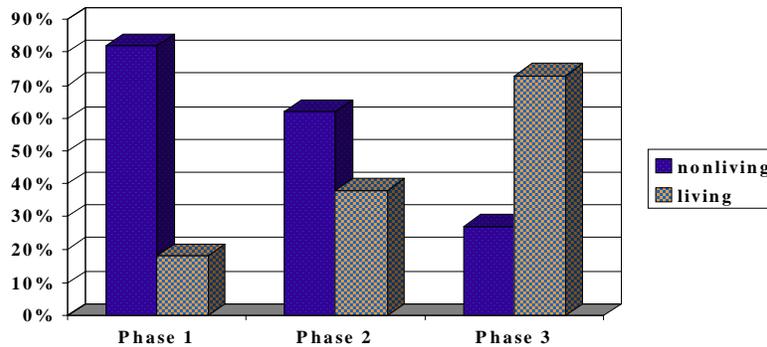
In the first phase of treatment, 82 percent (9 out of 11) of David's sandplays were nonliving and 18 percent (2 out of 11) were living. The living objects he used in this stage were dinosaurs, knights, and soldiers. Nonliving sandplays decreased to 62 percent and living sandplays increased to 38 percent in phase two. In phase three, David used living miniatures in 73 percent of his sandplays, while 27 percent were nonliving sandplays. Overall, the number of living trays increased and the number of nonliving trays decreased.

After looking at the percent of living and nonliving sandplays in each phase, I identified the miniatures David used predominantly in the living and nonliving categories. In the living category, David used both humans and animals (see Figure 2). During the first phase of treatment, humans and animals were used equally in 9 percent (1 out of 11) of his sandplays. In the second phase, humans were used in 7 percent (1 out of 13) and animals in 31 percent (4 out of 13) of David's sandplays. David's use of humans increased to 45 percent (5 out of 11), and his use of animals increased to 64 percent (7 out of 11) during the third phase.

Figure 2
Living Objects in Sandplays
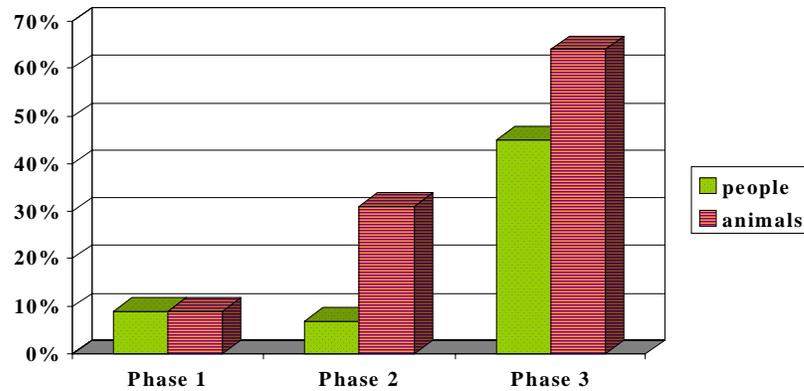
Three types of nonliving miniatures were predominant in David's sandplays: houses, cars, and marbles (see Figure 3). During the first phase, David used cars in 55 percent (6 out of 11) and marbles in 45 percent (5 out of 11). He did not use houses in the first phase. David added cars to 62 percent (8 out of 13) of his sandplays in the second phase, marbles to 8 percent (1 out of 13), and houses to 15 percent (2 out of 13). In the third phase, cars were present in 45 percent of David's sandplays (5 out of 11), marbles in 27 percent (3 out of 11), and houses in 18 percent (2 out of 11). The percentages of objects do not add up to 100 percent across phases because objects were counted independently from phase to phase.

Figure 3
Nonliving Objects in Sandplays
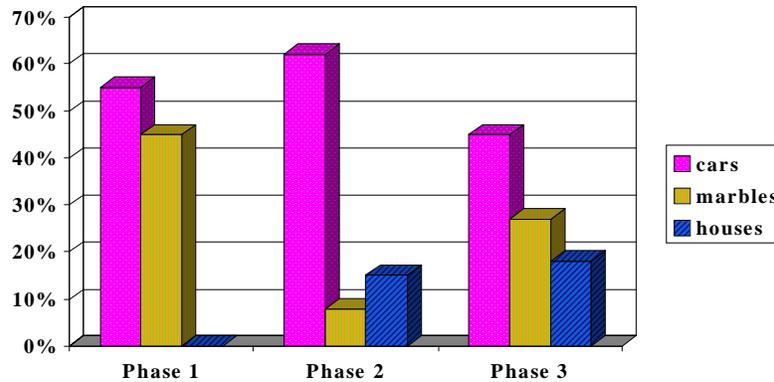
In addition to looking at whether David created a living or nonliving sandplay, I calculated the number of miniature categories that David used within each sandplay. I decided to look at the number of miniature categories represented in David's sandplay, since barren worlds or worlds with few miniatures often indicate that the child views their "inner and outer worlds as bleak and lacking in growth, life, and health" (Cockle, 1993, p. 15). Some examples of miniature categories are cars, soldiers, and dinosaurs. I separated David's sandplays into three groups—those using one category of miniatures, those using two to three categories of miniatures, and those using four or more categories of miniatures (see Figure 4). David used one category of miniatures in 64 percent (7 out of 11) of the first phase sandplays, 31 percent (4 out of 13) of the second phase sandplays, and none of the third stage sandplays. Two to three categories of miniatures were used in 36 percent (4 out of 11) of first phase sandplays, 38 percent (5 out of 13) of second phase sandplays, and 18 percent (2 out of 11) of third phase sandplays. David did not use four or more categories of miniatures in the first phase. However, four or more

categories of miniatures were used in 31 percent (4 out of 13) of second phase sandplays and 82 percent (9 out of 11) of third phase sandplays.

Figure 4
Sandplay Categories of Miniatures
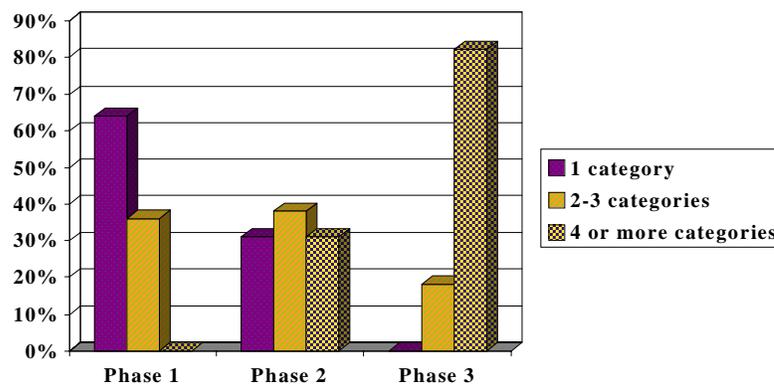
Sandplay Process

Several researchers have examined the process of children's sandplay and labeled the play as either static or dynamic. Khan (1993) defines static sandplay as "referring to a fixed position…items are placed into the box and adjusted until the picture is complete; it is like a composed photograph" (p. 244). Dynamic sandplay is defined as "referring to action; the sand player creates a story; it is analogous to a moving picture" (Khan, 1993, p. 244). Gil (1998) applied the concept of dynamic and stagnant play specifically to traumatized children and made the distinctions presented in Table 1. After observing David's repetitive play and reading about static and dynamic play, I became interested in categorizing David's sandplay into these two categories because the movement from static to dynamic play is another sign of positive change in a child's play.

Table 1
Characteristics of Dynamic and Stagnant Post-Trauma Play

Dynamic Post-Trauma Play	Stagnant Post-Trauma Play
Affect available	Affect remains constricted
Physical fluidity	Physical constriction
Range of interaction with play	Limited interaction with play
Range of interaction with clinician	Limited interaction with clinician
Play changes or adds elements	Play stays precisely the same
Play occurs in different locations	Play conducted in same spot
Play includes new objects	Play limited to specific objects
Themes differ	Theme remains constant
Outcome differs & healthier adaptive responses emerge	Outcomes remain fixed and nonadaptive
Rigidity loosens over time	Play remains rigid
After-play behavior indicates release	After-play behavior shut-down
Out-of-session symptoms maintain or decrease	Out-of-session symptoms maintain or increase

(Gil, 1998, p. 8)

Using Gil's (1998) guidelines, I categorized each of David's sandplays as either static or dynamic (see Figure 5). For instance, sandplays in which David repetitively moved miniatures (i.e. cars) for the entire session were classified as static sandplays, because they fit many of the above criteria for stagnant play. In the first phase, 91 percent (10 out of 11) of David's sandplays were static and 9 percent (1 out of 11) were dynamic. During the second phase, 54 percent (7 out of 13) of the sandplays were static

and 46 percent (6 out of 13) were dynamic. By the third phase, David's static sandplays decreased to 18 percent (2 out of 11) and his dynamic sandplays increased to 82 percent (9 out of 11).

Figure 5
Static and Dynamic Sandplay
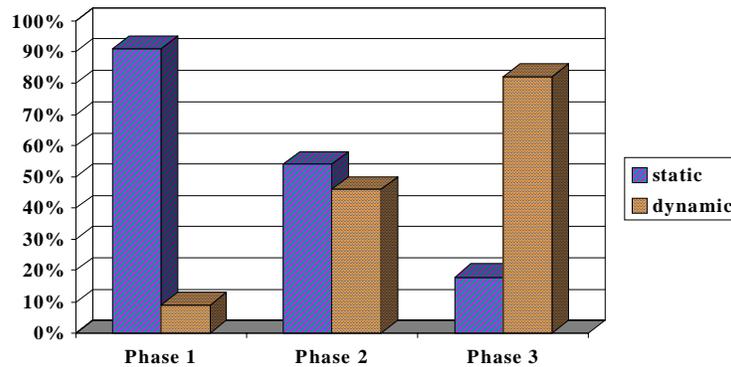
In addition to classifying each sandplay as either static or dynamic, I identified specific behaviors that David displayed while making each sandplay. Some process oriented behaviors that were prominent throughout David's 35 sessions include: repetitive movements, themes of aggression, burying objects, filling objects with sand, and pouring sand over his hands (see Table 2 and Figure 6). Repetitious movement, burying objects, filling objects with sand, and pouring sand over hands were all recorded in my progress notes. Aggression in trays was determined by the type of miniatures used in the tray and how David played with the miniatures. For instance, scenes in which David used miniatures to hit, kick, shoot, bite, or throw things at each other were coded as aggressive sandplays. The percentages for these behaviors add up to more or less than 100 percent because a tray could fit in more than one category. Therefore, it is possible that all five of the behaviors could have been present in a single sandplay.

Table 2
Sandplay Processes Percentages

	Repetitive Motions	Aggression	Burying Objects	Filling objects with sand	Pouring sand over hands
Phase 1	91%	9%	27%	18%	45%
Phase 2	85%	54%	31%	38%	15%
Phase 3	55%	27%	36%	18%	0%

Figure 6
Sandplay Process
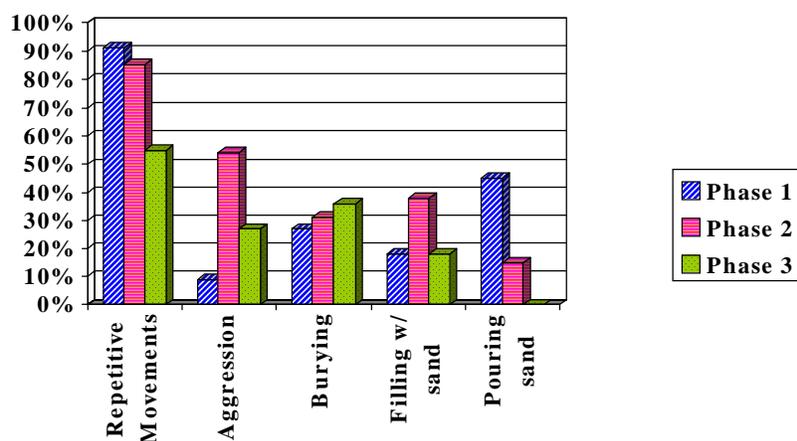
Interaction during Sandplay

I looked at the verbal and nonverbal interaction (see figure 7) between David and me in each session. I became interested in recording the level of interaction between David and I after little interaction with David in our first session. Sessions in which David did not make any verbal statements or nonverbal contact (i.e. eye contact or gestures) were classified as withdrawn sessions. Sessions in which David initiated little verbal or nonverbal contact with me were classified as minimally engaged sessions. I

classified sessions as an engaged when, David initiated verbal contact and made eye

contact. The verbal statements David made in minimally engaged sessions were often

unrelated to his sandplay work. For instance, David once told me about his new game.

The contact in engaged sessions was for a longer period of time than in minimally

engaged session and the verbal statements were related to his play or therapy work. For

example, in one session David made eye contact off and on throughout the session. After

he completed his sandplay, he told me about a couple of the miniatures used in the tray

and what the miniatures were doing. In particular, he named one of the dog miniatures

and showed me the house where the dog lived and that he had food to eat.

Figure 7
Interaction during Sandplay
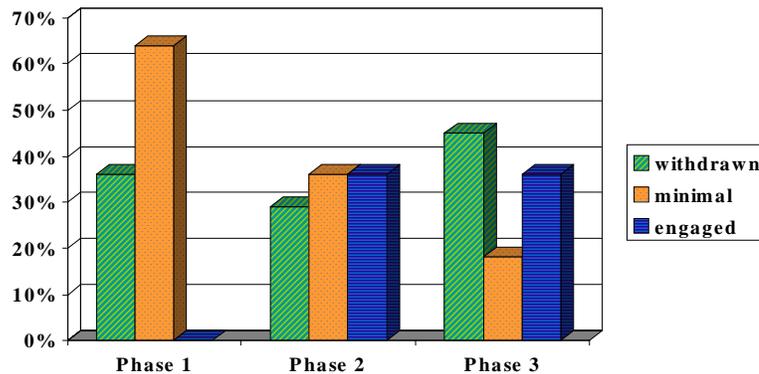
Patterns of withdrawn behavior were evident throughout the three phases. For

instance, the sessions in which David did not make any eye contact or verbal statements

were usually clustered together. Each therapy phase had one period with two or more

consecutive withdrawn sessions. In phase one, the back to back withdrawn sessions were

during the week preceding Mark's disclosure that he had sexually acted out with his

sister, which David witnessed. In phase two, there were three withdrawn sessions in a

row. The withdrawn sessions coincided with Mark's announcement that he and David had sexually acted out and with the treatment team's discussion of foster care placement with the family. The three consecutive withdrawn sessions in phase three corresponded with the time period that David said that his father was dead and that he created his burial sandplay. During each of these difficult family experiences, it seems that David retreated to his inner world and appeared withdrawn and nonverbal. After observing this behavior on numerous occasions, I wondered if retreating inward was David's way of coping with the disorganization of his environment and the emotional pain of his experiences. In many of the withdrawn sessions, David's facial expressions indicated he was sad, which would be appropriate given his experiences.

Although David's level of interaction throughout the phases may seem regressive to some, I do not see it as such. During the third phase, David had just moved to his foster home and was dealing with many adjustments. The data show that David was withdrawn in more sessions during the third phase. However, in his life outside of therapy, he made many improvements in communicating with others. For instance, David made friends and would often get together to play with them, whereas he did not have any friends in the first two therapy phases. I also noticed that David and his foster mom would often interact with each other, laughing together, or reading together when I went to the waiting room to get him. I wondered if the relationship David was developing with Karen, coupled with the encouragement and education on social skills she helped him with, enabled him to interact more with others during this last phase. In contrast, David's relationship with me allowed him the freedom and the opportunity to

submerge himself in his play and to express his sad and angry emotions through the play, thus accounting for his withdrawn, self-absorbed stance.

DISCUSSION

Over the 10-month therapy period, there were many significant changes in the content and process of David's play. David went from primarily using nonliving miniatures to using living miniatures in his sand worlds. Specifically, the use of people and animals increased in David's third phase sandplays. The diversity of miniature categories David used also increased from mostly one category per session in the first phase to mostly four or more miniature categories per session in the third phase. David's sandplay moved from primarily static play in the first phase to more dynamic play in the third phase. Additional process changes in David's play included: decreased repetitive movements, increased aggression in the second stage, increased filling of objects during the second stage, and decreased pouring of sand over hands.

During David's first therapy session after entering foster care, I noticed that he used living miniatures that he had never selected before. I immediately wondered if David's change in environment had anything to do with the miniatures he selected that day and if his future trays would show an increase in living objects. Months later, I learned that the number of people and animals David used in sandplays did increase while in foster care. The increase in living objects could signify many things. David's increased use of people in sandplays may represent his changes in relating to other people. For instance, David developed a warm relationship with his foster mother and made friends at school. Therefore, David appeared more connected to people in this outside world during the third phase and this may have been reflected in the appearance

of more people in his play. Another explanation for David's increase use of living objects could be that his perception of his world changed. When David lived at home he experienced abuse and neglect, painting a bleak, lifeless and threatening perception of the world for David. However, the transition to a safe environment, with one-on-one attention from an adult brought about many new opportunities for David to see the world as full of life and growth.

Sandplay researchers have also provided possible meanings for the exclusion of living objects within trays. Mitchell and Friedman (1994) state that the omission of people in children's sandplays often suggests a disturbance in their interpersonal relationships. Bowyer (1970) and Cockle (1993) list unpeopled sand worlds as one of signs of regression in children's sandplay.

The movement from static to dynamic sandplay is another sign of positive change. David's early sandplay met many of the qualifications of post-traumatic play as defined by Jones (1986) and Terr (as cited in Gil, 1991). However, his repetitive play did not consist of replaying the traumatic experiences of sexual abuse, but repetitively moving cars or other miniatures in the same series of movements. Thus, David's play contained both similarities and differences to Jones' and Terr's definition. The miniatures and repetitive movements David used in his first sandplay were evident in many of his later sandplays. In Harper's (1991) study of sexually abused children's sandplay, she found that "the first world was definitive and the subsequent ones a repetition of this same world" (p. 94). Nonetheless, while he was in the foster home, his play dramatically shifted to dynamic play during the third phase of therapy. Gil (1998) describes dynamic post-traumatic sandplay as "providing ample opportunities for

symbolic healing by acknowledging reality and its impact, and by allowing children to find explanations and responses that promote mastery and control" (p. 9). Thus, the repetitious nature of David's play may have been essential in the resolution of his past trauma, as the sandplay provided opportunities for mastery and control.

The expression of children's aggression in play also can be viewed as a good prognostic sign, since the release of suppressed hostility through play can lead toward resolution of the conflict (Bowyer, 1970). In David's case, I viewed the expression of aggression as a good sign because it was an obvious change from the repetitive play sequences in phase one and the sandplay seemed to give him opportunities to release his frustration and anger through the use of symbols. Kalff (1980) discusses three stages of sandplay work—"1) the animal, vegetative stage, 2) the fighting stage, and 3) adaptation to the collective" (p. 32). In this second stage, battles appear repeatedly in the sand work and the child becomes confident "that he can take upon himself the battle with external influences and he can come to grips with them" (Kalff, 1980, p. 33). In Homeyer and Landreth's (1998) list of sexually abused children's play behaviors, they also list battles as one prominent play theme. David's sandplay showed the most aggression during the second or middle phase. During this time frame, his brother was sexually reactive toward him and he discovered that he would be removed from his home. While aggression was a good prognostic sign in David's case, it is not always so. Children who become fixated on violence in play may need special attention.

Burying miniatures in the sand is another act that can have reparative value for sexually abused children. Cockle (1993) found that burying is more evident in the difficulty coping group sandplay, 63 percent, versus the 14 percent in the successfully

coping group. Grubbs (1994b) discusses a sexually abused child's burial of the person who sexually abused him/her as being a significant act in the healing process. Burying the abuser can give the child an opportunity to express their feelings of sadness and anger toward the person and take a stand against the abuser (Grubbs, 1994b). David's sandplay in which he buried the family may have symbolized David's attempts to heal the wounds of being abused by his father and then being removed from the rest of his nuclear family.

Another process-oriented action in David's play was the filling of objects with sand. For instance, David often filled open-mouthed dinosaurs mouths with sand and then emptied them. He also filled and emptied cups. Homeyer and Landreth (1998) list repetitively filling and emptying objects with sand as one theme in sexually abused children's sandplay. Interestingly, the filling and emptying in David's play was the highest during the second phase or when his brother was sexually reactive toward him. In the first therapy phase, David also frequently scooped a big handful of sand and let the sand slowly shift through his fingers. Dale and Lyddon (2000) state that "because the 'sand feels wonderful to the fingers and hands, creating an ideal tactile and kinesthetic experience' (Oaklander, 1978, p. 167), it can produce feelings of relaxation (Reed, 1975), and grounding (Carey, 1990) for some clients" (p. 146). For David, the behavior seemed to be self-soothing and by the third phase this behavior was nonexistent.

Kalff (1980) contends that a child's sandplay themes evolve over time as a result of the therapeutic growth process and inner healing. As this healing process occurs silence is essential (Ammann, 1991). Throughout David's sandplay experience he was silent as he made the worlds, and I maintained my role as a witness and supporter. On occasion David did verbalize the narrative or meaning behind the play, but for the most

part he did not share the meanings of his play with me and I did not make inquires. Harper (1991) compared sexually abused, physically abused, physically and sexually abused, and nonabused children's sandplay and found sexually abused children to be the most reluctant to provide a narrative of their sandplay. The results of this study correspond to my experience with David. For example, David's interaction with me only fit into the engaged category, making verbal statements about his sandplay and eye contact, in 36 percent of second and third phase sandplays. During the first phase, David did not have any engaged sessions.

In order for children to engage in healing play, they must be in a family environment that is supportive of their therapeutic progress. To date, there have not been any empirical studies or case studies that discuss in-depth the child's family environment in relation to the child's sandplay movement. Grubbs (1994b) refers to the connection between a healing environment and movement within the child's play. She states that "it appears that the healing image does not typically progress for children in abusive families unless their environment changes. The change may be either the parents entering therapy and becoming more nurturing, or in severe cases, having the child placed in an environment that supports the healing" (p. 75). In Grubbs (1994b) case study of several sexually abused children's sandplay, she concluded that "the progression of this healing was very dependent upon support from their external world" (p. 84). This appeared to be true in David's case, since positive changes in his sandplay content and process were quite noticeable from phase one and two to phase three, when he entered into a foster home.

CLINICAL IMPLICATIONS

I learned a great deal from being a participant in David's therapy. I was able to observe first-hand the benefits of using child-centered play therapy with a nonverbal, sexually abused child. David responded well to leading his own play and was able to pick the play medium that was most conducive to his style of expression. The consistent use of sandplay enabled David to gain mastery through his symbol play. Furthermore, David had ample opportunities to engage in post-trauma sandplay, which allowed for restructuring of traumatic events through controlled recall and subsequent organization of his perceptions of the past trauma.

Through careful observation of David's sandplay, I noticed that certain miniatures or themes were prevalent when family events occurred. Therefore, David's sandplay not only helped me gain a glimpse of his inner world, but also his outer or family world. In order to understand the play changes, documentation of the sandplays and communication with David's family was important throughout the therapy process. I also found it helpful to look at changes in the play content and process, along with the therapist/child interaction. Using these categories allowed me to gain a broader perspective of the changes in David's play.

Not only was the documentation of David's play a fascinating process for me, but using child-centered play therapy was also a learning experience. In the beginning of therapy, I often questioned if I was "doing it right". My training as a family therapist often focused on using directives or asking questions; however, with David I did neither. I typically sit across from the sandplay he was making and quietly observed his world creation. At times, this was very hard, given my inclination to ask questions. David

would make an interesting tray and often left the room without any verbal clues to what this could mean. Thus, I was left to formulate my own meanings. During one session, I decided to make several observations or summations of what David was doing in the session, as child-centered therapists often do within therapy. For instance, "you are moving the cars in circles". David did not respond to these observations, but seemed perturbed that I was speaking during the session. Afterward, I didn't make any observations until he had completed his sandplay. Some times David choose to respond to my observations and other times he remained quiet. In the end, I learned that children have an amazing capacity to direct their own healing process. David knew when it was helpful for him to talk and when he needed to be quiet and focus on his sand work.

I also learned that although David's play was very important, it occurred within the context of a relationship with me. I provided David a safe, quiet space of his own. When David lived with his biological family, I often wondered if this was the only space or time he had all to himself. I was also respectful of David's decision to not talk and of his play direction. Furthermore, I did not place any demands upon David, thus giving him an opportunity to tell his story through sand world creations.

CONCLUSIONS

In David's sandplay, there was a dramatic shift in the content and process of his trays from phase one and two to phase three. Phase three marks the transition from his home to foster care. His home environment was unsafe due to his brother's sexual reactivity and his mother's inability to provide a safe environment at that time. Foster care was a safe environment for David. Once David was in a safe external environment, he created many reparative worlds and shifts in his play became evident. Two noticeable

shifts in the sandplay include the change from nonliving to living miniatures, and the change from static to dynamic play. David also used more categories of miniatures in his third phase sandplay. Repetitious movements and pouring sand over his hands decreased from phase one to three. Aggression was the highest in phase two, when Mark was sexually reactive toward him. It is possible that these transitions in his play were a natural part of the therapeutic progression and not attributable to the change in his environment. However, I believe that the positive changes in David's play were related to being in a safe and supportive external environment. In addition, by the third phase of therapy, David had also developed a warm relationship with me, where he felt comfortable and safe to engage in healing play.

Regardless of the contributors to David's play changes, the progression of David's sandplay was both fascinating and intriguing to observe. As I used child-centered play therapy with David, I also gained a better understanding of how this mode of therapy can benefit nonverbal, sexually abused children. David was given the control inherent in child-centered play therapy, allowing him to have compensatory mastery opportunities. The sandplay also gave David ample opportunities to create his internal and external world experience. Ammann (1991) contends that the client's hands working through the sand can "build the bridge between [their] inner world and the external world" (p. 2). In David's sandplay, he was able to externalize many of his feelings about family experiences and events. As a participant in the therapy process, I felt honored to witness the making of David's sand creations and play transformations.

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APPENDIX A

LITERATURE REVIEW

In order to provide the background and understanding for this case study, research on several topics of importance will be outlined. First, an overview of play therapy and the importance of play will be provided. Then, the origins and principles of child-centered play therapy will be examined, and the research on using child-centered play therapy with children who have been sexually abused will be presented. Next, the literature on sandplay therapy will be reviewed, along with the research on utilizing sandplay with children who were sexually abused.

PLAY THERAPY

When working with children in a therapeutic context, research supports the use of play for a variety of reasons. The language of adults is words, the language of children is play. Adults most often express their feelings and thoughts through words, while children's means of communication is play and activity (Landreth, 1991). Children often lack the emotional and cognitive development to portray their inner thoughts and feelings with words (Johnston, 1997). Landreth, Baggerly, and Tydall-Lind (1999) state that the "utilization of play as a communication tool enables a child to transcend the restrictions presented by his or her inability to understand or articulate abstract thoughts" (p. 274). Therefore, it seems natural that children express their difficulties and worries through play in a therapeutic environment, just as adults verbalize their difficulties and worries (Axline, 1947). Landreth (1991) goes on to define play therapy as "the dynamic interpersonal relationship between a child and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe

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relationship for the child to fully express and explore self (feelings, thoughts, experiences, and behaviors) through the child's natural medium of communication, play" (p. 14).

Research studies provide support for the effectiveness of play therapy and recommend using play therapy with children. Landreth, Homeyer, Glover, and Sweeney (1996) conclude that play therapy is an effective therapeutic medium when working with children's issues, such as abuse and neglect, aggression and acting out, attachment difficulties, autism, chronic illness, deafness and physical challenges, dissociation and schizophrenia, emotional disturbance, enuresis and encopresis problems, fear and anxiety, grief, hospitalizations, learning disabilities, mental challenges, reading difficulties, selective mutism, low self-esteem, special maladjustment, speech difficulties, traumatization, and social withdrawal. These authors found 92 studies that documented the effectiveness of play therapy. In 23 of these studies, researchers reported alleviation of the child's presenting problem in 10 or fewer sessions (Landreth, Homeyer, Glover, & Sweeney, 1996).

In the therapy environment, play therapists provide carefully selected toys, games, and materials for children's self-expression. Landreth (1991) discussed what the selected toys should provide for children--expression of a wide range of feelings, exploration of real life experiences, reality testing of limits, development of a positive self-image, development of self-understanding, and an opportunity to develop self-control. The toys and materials that can promote these aspects include: real-life toys (i.e. doll family, puppets), acting-out aggressive toys (i.e. toy soldiers, rubber knife), and toys for creative expression and emotional release (i.e. sand tray, water) (Landreth, 1991).

Within the play therapy realm, there are many different schools of thought. For example, O'Connor and Braverman (1997) discuss 13 different approaches to play therapy. The play therapy theories examined include: Child-Centered, Psychoanalytic, Cognitive-Behavioral, Jungian, Filial, Developmental, Gestalt, Fostering Attachment through Family Theraplay, Ecosystemic, Ericksonian, Adlerian, Dynamic Family Play Therapy, and Strategic Family Play Therapy. Each of these theories differ somewhat on the therapy goals, model of psychopathology, principles, and applicability for age and ethnicity. This literature review will specifically focus on the child-centered play therapy school of thought, since this is the model of therapy used in the current study.

CHILD-CENTERED PLAY THERAPY

Child-centered play therapy flows conceptually from the work of Carl Rogers and his development of client-centered therapy. Rogers expanded the work of relationship therapists and proceeded to develop nondirective therapy. Later, Rogers referred to nondirective therapy as client-centered therapy and then person-centered therapy (Landreth, 1991). Axline (1947) extended Rogers' work toward children and dubbed her approach client-centered play therapy. Landreth, founder and director of the Center for Play Therapy in Texas, coined the term child-centered play therapy to describe his work with children (Landreth, 1991). Throughout this paper, I will use the terms nondirective play therapy and child-centered play therapy interchangeably.

Carl Rogers

Rogers primarily conceived client-centered therapy during the years 1938 to 1950; however, he continued to expand upon this theory throughout his life (Rogers & Sanford, 1985). Rogers and Sanford (1985) defined client-centered therapy as

"developing a way of being with persons that facilitates healthy change and growth" (p. 1374). In <u>A Way of Being</u> (1980), Rogers declared that "individuals have within themselves vast resources for self-understanding and altering their self-concepts, basic attitudes, and self-directed behavior; these resources can be tapped if a definable climate of facilitative psychological attitudes can be provided" (p. 115). Rogers labeled this capacity for solving one's own problems, growth, and healing the *self-actualizing tendency*. Axline (1947), who expanded Rogers client-centered approach toward children, spoke of the self-actualizing tendency as an "assumption that the individual has within himself, not only the ability to solve his own problems satisfactorily, but also this growth impulse that makes mature behavior more satisfying than immature behavior" (p. 15).

Rogers (1957) deemed the following three factors--congruence, unconditional positive regard, and empathy--as necessary and sufficient conditions for growth and successful therapeutic outcome. Congruence refers to the therapist's self-awareness and genuineness with the client. For example, the therapist is aware of her/his thoughts and feelings during the session and openly communicates these thoughts and feelings with the client (Rogers & Sanford, 1985). Thus, a therapist feeling uncomfortable with information that a client just shared may verbalize this feeling to the client.

Unconditional positive regard or acceptance describes the therapist's deep and genuine caring for the client as a person and the acceptance of the client's human qualities (Rogers, 1957). For instance, Rogers and Sanford (1985) describe unconditional positive regard as "the kind of caring that the client-centered therapist desires to achieve

is gullible caring, in which clients are accepted as they say they are, not with a lurking suspicion in the therapist's mind that they may, in fact, be otherwise" (p. 1379).

Empathy involves trying to understand the client's inner world and communicating the client's feelings and thoughts in a manner that is attuned to the client's language and current mood (Rogers, 1957). Miller, Duncan, and Hubble (1997) describe empathy as

> giving undivided attention to what the client is saying, attempting to understand the client's experience, and then sharing that understanding with the client. Of course, this does not mean that the therapist must understand everything the client says. Clients frequently report that they experience an empathic connection even when they know the therapist doesn't exactly understand what they are feeling or experiencing. What seems to matter most is that clients perceive the therapist as trying, even struggling, to understand what they deem important and meaningful (p. 112).

Rogers (1970) also discussed six tenets of being in a therapeutic relationship: hearing the other person and being heard by that person, presenting yourself as real and discovering realness in another person, and permitting freedom to others and learning that someone else cares for, accepts and admires you. As Rogers worked with clients, he strove to incorporate these principles as the relationship developed. Through providing a growth-producing environment for clients, he helped them determine and discover their innermost strengths. In addition, the incorporation of these tenets make Rogers' approach more of an equal relational interchange between the client and therapist, rather than a traditional hierarchical relationship with the therapist in charge.

Rogers' work fell out of fashion during the 1960's and 1970's, with the rise of behaviorism. However, recently Miller, Duncan, and Hubble (1997) have incorporated Rogers' work into their research on the four common factors that contribute to change in therapy. Drawing on the work of Lambert and Bergin (1994), Miller, Duncan, and

Hubble (1997) discuss the therapeutic relationship as comprising 30 percent of the

variance in therapy outcome. They state that "the latest research and thinking indicate

that strong alliances' are formed when clients perceive the therapist as warm, trustworthy,

nonjudgmental, and empathic" (Miller, Duncan, & Hubble, 1997, p. 28). Clearly,

Rogers' contributions and focus on the therapeutic relationship have been influential, as

there are now more than 1,000 research articles on the power of the "therapeutic alliance"

(Orlinsky, Grawe, & Parks, 1994).

Virginia Axline

Axline, a student and colleague of Rogers, applied many of the principles of

client-centered therapy work with children. Axline (1947) developed eight basic

principles to facilitate therapists in nondirective interactions with children. Landreth

(1991) later revised these eight basic principles to include:

1. The play therapist is genuinely interested in the child and develops a warm, caring relationship.
2. The play therapist experiences unqualified acceptance of the child and does not wish that the child were different in some way.
3. The play therapist creates a feeling of safety and permissiveness in the relationship so the child feels free to explore and express him- or herself completely.
4. The play therapist is always sensitive to the child's feelings and gently reflects those feelings in such a manner that the child develops self-understanding.
5. The play therapist believes deeply in the child's capacity to act responsibly, unwaveringly respects the child's ability to solve personal problems, and allows the child to do so.
6. The play therapist trusts the child's inner direction, allows the child to lead in all areas of the relationship, and resists any urge to direct the child's play or conversation.
7. The play therapist appreciates the gradual nature of the therapeutic process and does not attempt to hurry the process.
8. The play therapist establishes only those therapeutic limits that help the child accept personal and appropriate relationship responsibility (p. 77-78).

Child-centered play therapy gives the child the opportunity to play out his/her

feelings and problems, just as adults often talk about their feelings and difficulties in

therapy (Axline, 1947). Because children express themselves through play using play

instead of talking as the therapeutic medium for children is natural (Axline, 1947).

During the play, Axline (1947) assumes the child will direct the play in a way that is

productive for them to work through their struggles. For instance, a child struggling with

the death of a parent may play out death scenes, bury people or objects, or draw pictures

related to their experience. These therapeutic tasks may help the child resolve issues

related to the parent's death that they could not express in words. Today, Axline's

premise of the child guiding the play still lives. For example, Cockle and Allan (1996)

discuss how allowing the child the freedom to go where they need to in their play

establishes the premise for healing to occur.

In Axline's (1964) book, <u>Dibs in Search of Self</u>, she presents the story of a child

who would not talk or play. Axline used client-centered play therapy principles in her

work with this child. Her book describes Dibs' journey:

> Dibs experienced profoundly the complex process of growing up, of reaching out
> for the precious gifts of life, of drenching himself in the sunshine of his hopes and
> in the rain of his sorrows. Slowly, tentatively, he discovered that the security of
> his world was not wholly outside himself, but that the stabilizing center he
> searched for with such intensity was deep down inside that self (p. ix).

Dibs was able to come to these realizations as Axline provided a warm and supportive

therapy environment where he was able to share his struggles with her through play and

language.

<u>Garry Landreth</u>

Landreth (1991) has expanded upon Axline's original work and changed the name

from client-centered play therapy to child-centered play therapy. The basis of child-

centered play therapy rests on the therapist developing a warm relationship with the child,

which encourages the child's development and enhances their self-concept. Child-centered therapists let the child direct the therapy process, firmly believing that the individual has the capability for self-direction. Landreth (1993) concluded that the following four messages can be conveyed to the child through a nonevaluative relationship: "I am here, I hear you, I understand you, and I care about you" (p. 21). Each of these messages is lived out through the relationship the therapist develops with the child (Landreth, 1993). In addition, Landreth, Baggerly, and Tyndall-Lind (1999) stated that "a major premise of child-centered play therapy is that children are always communicating, not necessarily with words but with their bodies, their play, their total selves" (p. 279).

Many have described child-centered play therapy as a way of interacting or being with children; a philosophy that extends to all relationships (Landreth, 1993). "The child-centered philosophy of play therapy is just that: an encompassing philosophy for living one's life in relationships with children" (Landreth, 1993, p. 19). Jonas (1994) adds that child-centered play therapy is more than a set of techniques or a predetermined goals, but is "based on the therapist having and conveying a set of attitudes that encourages the child's development of an enhanced self-concept" (p. 8).

The role of the therapist in child-centered play therapy is to create a safe and protected space where the child can feel free and accepted to explore his/her inner self (Cockle & Allan, 1996). The therapist may weave in and out of roles during a session with a child, from player to observer. For instance, the therapist may become a part of the play process if the child invites her to do so. A child may invite the therapist to play a game or be a character in a puppet story. Other times, such as when a child is completing

a sandplay, the therapist may sit quietly and observe the child's play process. During the observation, the therapist may take note of the child's play objects, content, and process. Another role of the therapist may include making reflective or descriptive statements regarding the child's actions and content of play (Cockle & Allan, 1996). Landreth (1991) summarizes the child-centered play therapist's role as maintaining an active role in the play therapy process without directing or controlling the child's experience; however, the therapist is directly involved and genuinely interested in the child's feelings, thoughts, actions, and decisions.

As the child-centered play therapist works with the child, he or she "cultivates hypotheses that are tested over time; interpretations are used sparingly and then only after a great deal of observation" (Gil, 1991, p. 35). Landreth (1991) adds that "the therapist does not solve problems for the child, explain behavior, interpret motivation or question intent, all of which would deprive the child of opportunities for self-discovery" (p. 98). Furthermore, nondirective play therapists give their undivided attention to children, refrain from answering questions, and do not give directives (Gil, 1991). The therapist's purpose in not answering the children's questions is for the child to discover the answer instead of being told the answer. For instance, the child may ask the therapist if the sand is wet or dry. The therapist restates the child's question, "your wondering if the sand is wet or dry". The child then has the opportunity to go and investigate whether the sand is wet or dry.

Child-centered play therapists believe that the general objective of the therapy is for the child to direct himself/herself toward self-actualization. The therapist aids this process by being an understanding and supporting adult who facilitates the child's

positive growth experience and encourages the child to discover his/her internal

strengths. Landreth (1991) suggests that child-centered play therapy helps the child:

1. develop a more positive self concept,
2. assume greater self-responsibility,
3. being more self-directed,
4. become more self-accepting,
5. become more self-reliant,
6. engage in self-determined decision making,
7. experience a feeling of control,
8. become sensitive to the process of coping,
9. develop an internal source of evaluation, and
10. become more trusting of self (p. 80).

Child-Centered Play Therapy Research

In recent years, researchers have conducted many studies related to child-centered

play therapy. These studies demonstrate that child-centered play therapy can be used

with a variety of populations, such as children who have witnessed domestic violence,

children having difficulty reading, and children suffering from Trichotillomania. Kot,

Landreth, and Giordano (1998) investigated the effects of short-term, intensive, child-

centered play therapy with children who had witnessed domestic violence. Eleven

children in women's shelters participated in this study. These children received 12

individual 45-minute play therapy sessions during their stay of 14 to 21 days in the

shelter. The matched control group of 11 children in the shelter did not receive any play

therapy sessions. The analyses of covariance indicated that the children who received the

child-centered play therapy sessions scored significantly higher than the control group on

the standardized measures of self-concept, reduction of externalizing behavior problems,

and reduction of total behavior problems.

Crow (as cited in Landreth, Baggerly, & Tyndall-Lind, 1999) conducted a study

with 12 first-grade students who had been retained because of reading difficulties. These

12 students received ten 30 minute individual child-centered play therapy sessions. The children were matched with a similar control group. At the follow-up assessment, a significant improvement in the children's self-concepts was found in the children receiving play therapy sessions.

Besides outcome research on the effectiveness of child-centered play therapy, case studies have also been conducted. Barlow, Strother, and Landreth (1985) presented the case study of a 4-year-old child with Trichotillomania. This child was bald from pulling out all of her hair. After eight child-centered play therapy sessions the child's behavioral symptoms had disappeared and her hair had began to grow back. In addition, Jonas (1994) presents a case study of a 9-year-old child who had attempted suicide and documents the application of child-centered play therapy principles. After Jonas switched from using directive, goal-oriented therapy to child-centered play therapy the child began to take the lead in the sessions and her symptoms slowly disappeared as "she was free to develop her own sense of self-worth and strive toward her full potential" (p. iv).

Recently, several dissertations have been written on using child-centered play therapy. Darr (1994) described three case studies while investigating the development of the therapeutic relationship in a nondirective play therapy setting. Findings were based on the emergence of patterns in the three cases. The four patterns she found include: therapist's activity has a profound effect on relationship development with child; certain therapist responses enhance the therapeutic relationship; empathy, unconditional regard, and congruence must be integrated into the play therapy; and the importance of therapist awareness of the mutual influence between the child and therapist throughout therapy.

Luther (1994) presented a model for utilizing nondirective play therapy within a family systems treatment approach through a single case study. Change in the family system was assessed by measures of individual and family functioning, as well as through clinical data.

CHILD-CENTERED PLAY THERAPY WITH SEXUALLY ABUSED CHILDREN

Sexually abused children are often unable to explain or fully understand the impact of the sexual abuse. Thus, clinicians often look for external behavioral symptoms that signify underlying emotional difficulties (Gil, 1991). Some of the most common symptoms that children who have experienced abuse exhibit include: affective effects, such as guilt and shame, anxiety and fear, depression, and anger; physical effects, including psychosomatic complaints, injury, and pregnancy; cognitive and school-related problems; learned helplessness; aggressive and antisocial behaviors; withdrawal; self-destructive behaviors; psychopathology; sexual problems; poor self-esteem; and problems with interpersonal relationships (Lusk & Waterman, 1986). Furthermore, Browne and Finkelor (1986) found that the short-term effects specific to the sexual abuse of children include: fear or anxiety, depression, difficulties in school, anger and hostility, inappropriate sexual behavior, and running away or delinquency.

The impact of the sexual abuse trauma can manifest itself internally in several different ways. Pynoos and Eth (1985) assume that a psychic trauma occurs "when an individual is exposed to an overwhelming event resulting in helplessness, in the face of intolerable danger, anxiety, and instinctual arousal" (p. 38). Shengold (1979) refers to sexual abuse as a "soul murder" (p. 533) and believes that with sexual abuse "has a

lasting and profound effect…mobilizing certain defenses and structural changes, most of which tend to interfere with full, free emotional and intellectual development, and modifying the primal fantasies that motivate human behavior" (p. 534). Finkelor (1987) asserts that sexual abuse is "an experience that alters a child's cognitive orientation to the world and causes trauma by distorting the child's self-concept, worldview, or affective capacities" (p. 354).

This trauma may become evident in a variety of different ways. Gil (1991) discusses several symptoms that may result from the impact of the trauma— posttraumatic play, Post-Traumatic Stress Disorder (PTSD), and dissociation. Posttraumatic play occurs when the child's play is "compulsive, repetitive, unimaginative" (Jones, 1986, p. 379). During the posttraumatic play, the child may be oblivious to any observers and appear "cut off from reality" (Allan & Lawton Speert, 1993, p. 34). According to the DSM-IV-TR (2000), the characteristic symptoms of PTSD include "persistent reexperiencing of the traumatic event, persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness, and persistent symptoms of increased arousal" (p. 463). In young children, these symptoms may manifest themselves through repetitive play where themes or parts of the trauma are expressed (posttraumatic play), nightmares with unrecognizable content, and trauma-specific reenactments (DSM-IV-TR, 2000). Lastly, dissociation is defined by Gil (1991) as "a process of separating, segregating, and isolating chunks of information, perceptions, memories, motivations, and affects" (p. 22).

The trauma to the sexually abused child is not only intrapsychic. He or she often experiences a variety of life disruptions as well. For instance, the child may experience

the removal of a parent from the home, the imprisonment of a parent (if the parent was the abuser), testifying in court, being removed from the home (if the home is unsafe for the child), and feeling unsafe and distrustful of people.

The myriad of problems resulting from sexual abuse are best treated with therapy. Ellis, Piersma, and Grayson (1990) state that "few mental health professionals doubt that almost every child that has been sexually abused will experience psychological difficulties" (p. 525). Furthermore, Gil (1991) adds "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" (p. 47).

Both the child-centered approach and play therapy can help the sexually abused child heal. Numerous therapists and researchers have touted the benefits of using child-centered play therapy when working with sexually abused children. Gil (1991) stated "Because physical and sexual abuse are intrusive acts, the clinician's interventions should be nonintrusive, allowing the child ample physical and emotional space" (p. 59). Permitting the child the space created through the relationship can furnish the child with an opportunity to experience safety, appropriateness, and rewarding interactions, thus differing from the child's experience of abusive interactions within the family system or with the abuser (Gil, 1991).

The interactions between the therapist and child can also be healing for the child. Raumussen and Cunningham (1995) state that the "trusting therapeutic relationship is the core prerequisite for abused children, who have experienced much betrayal in their

relationships" (p. 7). Therefore, the use of child-centered play therapy can help build the rapport needed to develop a trusting relationship with a sexually abused child.

Other clinicians support the view that the therapeutic relationship is vital when working with children who have been sexually abused. Kelly (1995) discusses three factors associated with therapeutic progress of traumatized children—repetition for mastery, interpretation of affect and experiences, and therapeutic relationship. First, children who have experienced trauma often engage in a repetitive play process of replaying the traumatic events or experience with toys. This repetitive play process can help children gain mastery over the experience and assimilate the whole event, which was "too disturbing to be immediately bearable" (Kelly, 1995, p. 2). Second, although child-centered play therapists would not interpret the child's play process, Kelly (1995) suggests that the clinician apply the themes in the child's play directly to the traumatic event and label feelings that may be associated with the trauma. If the child doesn't play out the process or denies facts pertaining to the trauma, direct confrontation is recommended (Kelly, 1995). Lastly, the trusting relationship between the child and the therapist is described as providing stability, empathy, support, and acceptance. Furthermore, the components of a trusting relationship are viewed as "critical for reducing the emotional numbing and defensiveness that are typical of children whose self-worth and capacity to form relationships have been compromised as a result of abuse" (Kelly, 1995, p. 3).

Hall (1997) discusses how sexually abused children often experience *traumatic encapsulation*, a term coined by Burgess. Traumatic encapsulation occurs when "feelings regarding sexual abuse are defended against and the child is left essentially

unable to express his or her feelings openly" (Hall, 1997, p. 177). Because "play themes naturally and spontaneously emerge in a cascading display of emotional reactions to the abuse" (Hall, 1997, p. 177), child-centered play therapy can effectively liberate this blockage without translating the emotions into words. Thus, the play experience becomes a source of relief and mastery for the child, vital to the child's healing.

Allan and Lawton-Speert (1993) agree that play is the natural means for children to externalize the trauma and to be able to navigate through the pain at their own pace. The authors describe play therapy as providing a safe environment for the child to "enact, ingest, and assimilate trauma slowly over time" (Allan and Lawton-Speert, 1993, p. 35). As the child chooses the direction of the play, this gives him/her the opportunity to demonstrate competence through the mastery of their environment. This experience may be quite different for sexually abused children who are used to having little control in situations where adults have inflicted harm toward them.

In addition, play therapy has been described by others as the treatment of choice for physically, emotionally, and sexually abused children (Mann & McDermott as cited in Allan & Lawton-Speert, 1993). Play is viewed as important when working with children whom have been sexually abused, since the play allows the needed distance from the traumatic events through the use of symbolic materials and toys (Allan & Lawton-Speert, 1993).

The use of child-centered play therapy with sexually abused children is not without controversy. Some proponents believe nondirective play therapy alone should be used with sexually abused children, others support the use of a combination of nondirective and directive therapy, or directive therapy by itself. Several of the

disadvantages of using nondirective therapy listed in the literature include placing the child at risk for additional abuse or further inappropriate behaviors and trusting that the child will work through traumatic issues at their own pace (Rasmussen and Cunningham, 1995). For instance, a child who has been sexually abused may need therapeutic activities to help them develop an understanding of appropriate and inappropriate touching, coping skills, or anger management techniques. In nondirective therapy, these issues would only be addressed if the child brought them up. However, a directive therapist could plan specific activities to work on these issues with the child.

Although several studies document the effectiveness of using child-centered play therapy (Barlow, Strother, & Landreth, 1985; Bills, 1950; Kot, Landreth, & Giordano, 1998; Crow as cited in Landreth, 1993; Landreth, Homeyer, Glover, & Sweeny, 1996), few studies demonstrate its effectiveness with sexually abused children and none document the therapeutic process of one child. In the literature searches I conducted, I only found one outcome study discussing the effects of child-centered play therapy on sexually abused children (Zion, 1999). Zion's study discusses the effects of individual child-centered play therapy on sexually abused children's mood, self-concept, and social competence. In the study, 24 children, ages 3 to 9 years old, received 12 weekly play therapy sessions. The parents of the children completed the following assessments before therapy, immediately after therapy, and at a two-month follow-up: Joseph Preschool and Primary Self-Concept Screening Test, Behavior Assessment System for Children-Parent form, and Abuse Behavior Checklist. Results of the study indicated no pretest to posttest improvement within the group; however, eight children demonstrated clinical

improvement, four deteriorated, four improved with follow-up deterioration, and eight cases did not demonstrate any significant change.

Characteristics of Sexually Abused Children's Play

As children that have been sexually abused use symbolic materials and toys to express their trauma, researchers and clinicians have observed and recorded certain characteristics of their play. Homeyer and Landreth (1998) determined 140 play therapy behaviors of sexually abused children. They gathered this data from 249 play therapists who had each worked with 16 or more sexually abused children. The play therapy behaviors were then placed in the following categories: toy play, sand box play, art, toward the therapist, verbalizations, child's presentation, and themes of play. For the sake of space, I will only list those categories relevant to this case study. In the sand box play category, the following behaviors were listed:

> Repetitively filling and emptying cups of sand, smearing self with sand, making secret tunnels for hiding, building hills out of wet sand and poking holes in each of them, rubbing sand on genitals and thighs, covering genitals and thighs with sand, placing a snake or motorcycle between one's legs, dripping wet sand on a figure, and washing self/parts of body with sand (clearly cleansing, not sexualized play) (p. 65).

Under the category for child's presentation the behaviors listed include:

> Being in a trance-like state, while lying with water and sand, or while reenacting the abuse; appearing glass-eyed, stiff, and holding one's breath; sitting in a chair staring off into space; appearing to be cut off from reality and in a world of their own; incongruent presentation of self; needing to go to the bathroom excessively; and hiding for most of the session (p. 67-68).

Lastly, the following themes of play were listed:

> Good guys/people vs. bad guys/people; God vs. Devil; building new homes; taming wild animals; fixing things; drawing with themes of damage and violation; treating self like a "bad child"; guilt and shame; punishment; love, seduction, and sex; need for protection; rescue and danger; good figures unavailable for help;

being lost/burying; medical/healing play; identification with aggressor; hopelessness (p. 68).

Often sexually abused children's play exhibits signs of post-traumatic play, since they have experienced a severe trauma in which typical coping mechanisms are inadequate to prevent pain and anxiety. Jones (1986) describes post-traumatic play as "consisting of compulsive, repetitive, unimaginative activities in which the child is oblivious to the presence of the therapist" (p. 379). During this type of play, the child may appear to be cut off from reality or in their own world. Terr (1990) adds that children who have experienced a trauma have two behavioral options, they can either play or reenact. She further writes that reenactment or posttraumatic play can be observed through the following 11 aspects:

> Compulsive repetition; unconscious link between the play and the traumatic event; literalness of play with simple defenses only; failure to relieve anxiety; wide age range; varying lag time prior to its development; carrying power to nontraumatized youngsters; contagion to new generations of children; danger; use of doodling, talking, typing and audio duplication as modes of repeated play; and possibility of therapeutically retracing posttraumatic play to an earlier trauma (Terr as cited in Gil, 1991, p. 24).

Play and reenactment need to be distinguished between each other because typical children's play may involve reenactment (i.e. child pretending to complete household chore they watched parent complete), but the play does not involve the aforementioned aspects of posttraumatic play.

Through posttraumatic or repetitive play the child is aiming to gain mastery over the traumatic experience (Ellis, Piersma, & Grayson, 1990). Many clinicians' believe that posttraumatic play can be harmful to the therapeutic process and recommend stopping the behavior. Ellis, Piersma, and Grayson (1990) declare it is important to stop

the reenactment play because it places the child in the position to be victimized again or be the victimizer.

Child-centered play therapists take a different stance in working with sexually abused children engaging in posttraumatic play. The therapist's attitude remains constant and does not adhere to the issues or problems the child brings to therapy (Jonas, 1994, p. 25). Landreth (1991) declared that sexual, physical, and emotional abuse, along with other problems that bring a child to receive therapy, are not the treatment issue. The child should remain the main focus of treatment. Warner (as cited in Jonas, 1994) states that when using client-centered play therapy with traumatized children,

> Strong therapist directiveness is not essential. In fact, it seems to complicate the therapeutic process for many clients by raising authority issues and taking the timing of the interaction out of their control. We have found that when therapists…remain empathically connected with clients, a natural process tends to develop in which…memories…emerge on their own…clients seem to have an exquisite sense of timing, allowing just as much…material into consciousness at any given time as they can handle…and they seem to sense the order in which they are able to tolerate working on particular memories and life issues (p. 1-2).

SANDPLAY THERAPY

Most play therapy rooms are arranged to provide the child with many options of self-expression. For example, a dollhouse, puppets, art supplies, and therapeutic games are often some of the items available in the play therapy room. A sand tray and miniatures is another one of the choices play therapists offer to children. In this case study, David was drawn to the sand tray and miniatures and used them as his therapeutic medium. Miller and Boe (1990) define sandplay as "nondirective, projective play where miniature figures (trees, bushes, animals, people, fantasy figures, fences, houses, etc.) are chosen by the child and placed in wet or dry sand" (p. 249).

Before describing the specifics of sandplay therapy, there must be an understanding of the materials used in sandplay therapy. The sand tray is a box (28 ½ X 19½ inches with a depth of 2 to 4 inches) filled with sand (Grubbs, 1994a). Many therapists have a dry and wet sand tray available for the child to choose from. The interior of the box is painted bright blue to give the impression of water or sky (Mitchell & Friedman, 1994). A wide variety of miniatures are provided to choose from and to be used in creating a sand world. There are miniatures available to represent animate and inanimate images encountered in the external world, as well as those encountered within the inner imaginative world (Mitchell & Friedman, 1994).

Dora Kalff is the originator of the Jungian Sandplay method. Kalff studied under C.G. Jung and after hearing Margaret Lowenfeld describe the World Technique, a projective technique where children choose from numerous miniatures and create a world in a sandbox (Kalff, 1980), she decided to combine tenets of Jungian Theory and Lowenfeld's sand tray work to create her own therapeutic approach (Mitchell & Friedman, 1994). Kalff differentiated her work from Lowenfeld's by dubbing it "sandplay". Mitchell and Friedman (1994) state that "Kalff recognized that sandplay provided a natural therapeutic modality for the child, allowing the expression of both the archetypal and intra-personal, as well as connecting the child to outer everyday reality" (p. 50).

Kalff typically did not introduce sandplay to children in the first therapy session because she preferred to make a connection with the child first. After she established a connection with a child, she might ask them if they would like to do a sandplay. In explaining the idea to the child, she allowed them to touch the sand and she showed them

the blue bottom of the tray. Kalff then would present the miniatures and tell the child to "put in what speaks to you" (Mitchell & Friedman, 1994, p. 54).

As the child creates the sandplay, the therapist is a silent witness and observer to the process (Ammann, 1991; Grubbs, 1994a; Kalff, 1980; Mitchell & Friedman, 1994). Grubbs (1994a) discusses the importance of the therapist witnessing in a manner that is nonintrusive, empathic, and accepting of whatever the child expresses verbally or through their sandplay work.

The therapist does not seek to interpret the child's work in the sand. Miller and Boe (1990) suggest that when asking about the child's sandplay, the therapist keep within the metaphor that the child has provided. For example, if the child adds a large dinosaur to the tray, the therapist may ask the child to tell him/her more about the dinosaur after the tray is complete. The child may respond that the dinosaur is a mom dinosaur protecting her babies. Thus, the therapist would continue within the metaphor, possibly asking the child what the mom dinosaur is protecting her babies from.

After the child completes his/her sandplay, it is left intact until after the child has left the therapist's office. In addition, the therapist records the child's work on film or with slides. Therapists differ on whether the child is made aware of the sandplay pictures. Miller and Boe (1990) suggest that the therapist keep the sandplay record without the child's knowledge, in order to reduce the child's potential performance anxiety. Other therapists make the child aware of the sandplay pictures and give the child a picture of each sandplay.

Since the therapist does not seek to guide or intrude upon the child's work, sandplay provides a medium, which the child has the freedom to express him or her self

in any way he/she chooses. Mitchell and Friedman (1994) proclaim that "this nonverbal collaboration takes place on a level of consciousness that is outside the ordinary conscious, rational modes" (p. 54). Ammann (1991) adds that the client's hands working through the sand can "build the bridge between our inner world and the external world" (p. 2).

The sandplay also provides the child with the opportunity to access the deepest part of Self and express it symbolically in the sandplay (Kalff, 1980). As the child expresses Self over time, the themes of the sandplay often change as a result of the therapeutic process and the child's inner healing (Kalff, 1980). Each sandpicture or tray the child completes is a small piece of an intentional and purposeful whole in the healing process (Grubbs, 1994a). In the sandpictures, the therapist can look for struggles and strengths. The strengths guide the way for the individual's healing process, and the shifts in a child's sandplay work can denote an increase of resources (Grubbs, 1994a).

In addition to portraying Self in the sandplay, Grubbs (1994a) believes that children "continuously represent their perceptions, and possibly the reality, of their family experience in sandplay" (p. 202). For example, therapists can observe when mother and father symbols are unavailable, inadequate, competitive, or aggressive in the child's sandplay (Grubbs, 1994a). The sandplay may give the therapist clues to what has happened within the child's home environment and what needs to happen in the future (Grubbs, 1994a). Furthermore, in the case of intrafamily child sexual abuse, Grubbs (1994b) states that, "In my eight years of clinical practice with children who have suffered sexual abuse in their families, I have observed differences in their sandplay creations from children in nonabusive situations" (p. 429).

SANDPLAY THERAPY WITH SEXUALLY ABUSED CHILDREN

Grubbs (1994a) has written about the sexually abused child's use of sandplay in the healing process. "Sandplay gives the freedom and safety needed to express this trauma since there are no rules or pressure to speak. It gives them the 'freedom and sheltered place' to express and resolve the dissociation, conflict, and pain which is the result of sexual abuse" (Grubbs, 1994a, p. 195). Miller and Boe (1990) agree that in order for children to gain mastery over trauma they need a safe and predictable environment with a consistent adult to whom they can form an attachment.

Terr and Wheeler (as cited in Miller & Boe, 1990) both found sandplay's nondirective nature to be extremely useful for traumatized and abused children, since the children are given the opportunity to be in charge (Miller & Boe, 1990). The child may also use the sandplay to master traumatic experiences via repetitive play (Miller & Boe, 1990). Thus, it is vital that the same miniatures remain in the therapist's office in order for the child to have access to the figures as they repeat play scenes or in case the child becomes attached to using certain miniatures in their sandplay (Miller & Boe, 1990). Zinni (1997) discusses how sexually abused children are often intimidated into silence by their abuser; therefore, articulating thoughts and feelings about the abuse tends to be difficult. However, the use of sandplay helps the abused child express themselves through the worlds they create.

Grubbs (1994b) refers to sexual abuse as one of the most devastating traumas of childhood. Shengold (1979) believes that when children are sexually abused severe identity deprivation occurs, resulting in "mobilizing certain defenses and structural changes, most of which tend to interfere with full, free emotional and intellectual

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development, and modifying the primal fantasies that motivate human behavior" (p. 534).

Finkelhor (1987) states that sexual abuse "is an experience that alters a child's cognitive

or emotional orientation to the world and causes trauma by distorting the child's self-

concept, worldview, or affective capacities" (p. 354). Thus, the defense mechanisms that

aided the child in surviving the sexual abuse trauma can make it difficult for the child to

consciously remember the traumatic experiences (Grubbs, 1994b). Nonverbal, creative

art therapies, including sandplay, can be helpful in accessing the traumatic images that a

child has stored. The sandplay allows the child an opportunity to "play out his or her

feelings and impulses and reworks the traumatic experience over and over, both directly

and indirectly" (Grubbs, 1994b, p. 68).

In Cockle's (1993) study, she compared the differences in sandplay themes, play

characteristics, object use, and narratives between a coping group and a difficulty-coping

group of children. Five children in second and third grade were assigned to each group.

Over a two-month period, each child participated individually in four sessions of

sandplay. Results showed that the coping group "tended to view their world as more

balanced, vital, and organized, where others guide them, and they are safe" (Cockle,

1993, p. 1). In addition, children in the coping group were resourceful in dealing with

adversity and were hopeful about the future. The difficulty-coping group often perceived

their world "as barren, a struggle, and consisting of threat and danger" (Cockle, 1993,

p.1). They also lacked resourcefulness in dealing with adversity and were less hopeful

about the future.

Harper (1991) investigated the sandplay of sexually abused, physically abused,

sexually and physically abused, and nonabused children. Forty children (20 boys and 20

girls) participated in this study and each child completed one sand world. Findings revealed that the sexually abused children's worlds were representational and mixed, with themes of sexuality, protection, and nurturance. The physically abused children's worlds were classified as representational and fantasy with higher levels of aggression and disorganization, and themes involved conflict, chaos, and fantasy wish fulfillment. The sand worlds of the physically and sexually abused children were primarily representational and fantasy with considerable aggression, while their themes were diverse and used all of the miniature categories except domestic. The group of nonabused children made representational and fantasy worlds, with domestic and fantasy wish fulfillment themes.

In Grubbs (1995) exploratory study, she compared the sandplay process of sexually abused and nonclinical children. Five children participated in this study, two sexually abused and three nonclinical, with each child completing 12 sandplays. Grubbs found that the sexually abused children "created isolating or wartorn scenes that contained violent attacks on vulnerable victims and sadistic self-destruction" (p. 431). With abused boys, Grubbs observed that family and community groupings were used less frequently than in the worlds of the nonclinical children. In addition, the abused children's trays were often empty of life.

In summary, child-centered play therapy has been found useful when working with children with a variety of presenting problems. However, little research has been conducted connecting child-centered play therapy with the population of sexually abused children. Clinicians and researchers have conducted more research on sandplay therapy and its beneficial factors for children experiencing sexual abuse.

APPENDIX B

METHODS

In this descriptive case study, I described the sandplay of a 7-year-old male who experienced severe sexual abuse that resulted in PTSD. I illustrate prominent themes in his sandplay over a 10-month period and explore family events and experiences that coincided with certain play themes. Grounded theory methodology (Rafuls & Moon, 1996) is applied to group David's play themes into categories.

Participant and selection process

In this single case study, the participant was a 7-year-old male child who was sexually abused by his biological father. I chose this child for a variety of reasons. First, this child was primarily nonverbal during the therapy. At times he did verbally communicate with me; however, the conversations usually only lasted a minute or two. The silence was interesting to me because the children I typically work with talk during the therapy. The silence also made me wonder what was going on for this child inside. Second, this child's interest in sandplay also intrigued me. Upon entering the play therapy room, he would usually go straight to the sandtray and start removing miniatures from the shelf. As I observed this child's play over time, I noticed several distinct themes in the play and became interested in his play process. In the beginning, while playing, he often seemed as if he was in a trance-like state. He lined many of the miniatures up in rows and made series of repetitive movements in the sand. The play continued to evolve and new themes emerged the longer we worked together. As new themes did arise, I became interested in the connection of these new themes to current family experiences and events. I incorporate these experiences and events into this study.

Procedures

After receiving approval from the IRB, I presented the foster care worker (since the county has guardianship of the child), the biological mother, and the foster mother with the letter of explanation and the consent forms. I explained this study and asked for their permission to use the data I collected while working with the family.

The letter of explanation (Appendix C) for this study and the informed consent forms (Appendix D and E) both contain a statement about confidentiality. In order to protect the family's confidentiality, all of the family's names have been changed and each person was assigned a pseudonym. To further protect the family's confidentiality, some of the family background was altered. The community mental health agency where I work with the family is not identified, nor will the location of the center be mentioned. Furthermore, none of the progress notes were removed from the agency. Any information about the family or the child that was removed from the agency did not contain names or identifying information and was stored in a safe place.

Sources of Data

Several sources of data were utilized in this case study. First, data was used from my observation and participation in the therapy. After each session, I documented the session (progress notes) and made photographs of the child's sandplay creation. I also kept a journal of my reflections of the sessions. Other sources of data I used include the family background information, David's developmental history, assessments David's mother filled out before treatment began and at the sixth month of treatment (Child Sexual Behavior Inventory, Trauma Symptom Checklist for Children, Behavioral Emotional Rating Scale), the Child Depression Inventory that David completed midway

through treatment, and clinical reports from other professionals working with the family system.

<u>Data Analysis</u>

I used the first two stages of the constant-comparative method to analyze the multiple sources of data in this study (Glaser & Strauss as cited in Rafuls & Moon, 1996). Glaser and Strauss (as cited in Rafuls & Moon, 1996) discuss four stages to the constant comparative method: "1. comparing incidents applicable to each category, 2. integrating categories and their properties, 3. delimiting the theory, and 4. writing the theory" (p. 37). First, I used the two charts (Appendix F and G) to record selected miniatures, thematic content, play processes, and interactional data from each of my sessions with David. Then, I grouped the data into thematic categories. For instance, one play theme might include sandplay where soldiers are the miniatures selected and a battle is enacted. Next, I grouped the data into interactional categories. Once the coding of themes and interactional categories was complete, I looked at the dates David experienced specific external changes (e.g. moving to foster care). This data was then grouped into additional categories and compared to the play themes and interactions during the experience.

Throughout the process of reviewing the on-going data analysis, I met with my clinical supervisor and thesis advisor to discuss the coding and meaning of the data. Obtaining the input of other voices helped to increase the trustworthiness of this study. "The 'trustworthiness' of findings in a grounded theory study increases if multiple sources of data are utilized, if multiple methods of data collection and analysis are used, and if multiple investigators are involved" (Lincoln & Guba as cited in Rafuls & Moon, 1996).

After the data analysis was completed, this case study described David's sandplay themes. A rich description of specific sandplays helped to provide an understanding of the play themes in this sexually abused child's play. Furthermore, the play themes that were discovered were related to family events.

APPENDIX C

Letter of Explanation

Dear Parent,

I am currently a Master's student at Virginia Polytechnic and State University in the Marriage and Family Therapy Program. For my thesis, I am interested in using examples of David's therapy sessions to understand how play therapy can be beneficial to children who have been sexually abused.

I would like to use your child's therapy experiences, via case notes, pictures of sand trays, and the family background information you have provided me to write a description of your child's play. In this description, I will change all names of family members and disguise identifying information about your family. I will make every effort to ensure the confidentiality of you and your family.

One benefit of participating in this project is that you would be helping other families by contributing to the literature. There are no foreseen risks of participating in this project. There will not be any financial compensation for participating in this project. If you wish to withdraw from this project, you may do so at any time, except to the extent that permission has been acted upon. Withdrawing from the study will not interfere with the therapy being provided to your child.

Thank you very much for you and your family's participation in this study. If you have any questions or concerns, please feel free to contact me at xxxx, my thesis advisor, Dr. Eric McCollum, at xxxx, or my clinical supervisor at the xxxx, Dr. Eliana Gil, at xxxx.

Sincerely,

Cindy Mathis
Therapist Intern

APPENDIX D

Parent's Informed Consent

I give Cindy Mathis permission to use my child's, _____,

- Sandplay pictures
- Case notes
- Family background information

for the purposes of education, research, and professional publications and presentations. I understand that all clinical material will remain at the xxxx and that all identifying information of family members will be changed to ensure confidentiality.

I do not expect any financial compensation in exchange for this permission. I also understand that I may withdraw from this study at any time, except to the extent that permission has been acted upon.

If I have any questions regarding this consent, I can call Cindy Mathis at xxxx, her thesis advisor, Dr. Eric McCollum, at xxxx, or her supervisor at the xxxx, Dr. Eliana Gil, at xxxx.

Parent's Printed Name

Parent's Signature

Date

APPENDIX E

Guardian Informed Consent

 I give Cindy Mathis permission to use my child's, _____,

- Sandplay pictures
- Case notes
- Family background information

for the purposes of education, research, and professional publications and presentations. I understand that all clinical material will remain at the xxxx and that all identifying information of family members will be changed to ensure confidentiality.

Neither the child, his parents, his foster parents, nor xxxx County will receive any financial compensation in exchange for this permission. xxxx County Social Services may withdraw from this study at any time, except to the extent that permission has been acted upon.

If I have any questions regarding this consent, I can call Cindy Mathis at xxxx, her thesis advisor, Dr. Eric McCollum, at xxxx, or her supervisor at the xxxx, Dr. Eliana Gil, at xxxx.

Guardian's Printed Name
Guardian's Signature
Date

Sandplay Themes Form

Session #-_____   Date of Session-_____

      Objects   **Associations**   **External Changes**

Sandplay Process

Interactional Categories Form

Session #-_____   Date-_____

**Eye Contact   Nodding/Gesturing   # of Play Activities   Verbal Statements**

APPENDIX H

Picture of Phase Two Sandplay

APPENDIX I

Picture of Phase Three Sandplay
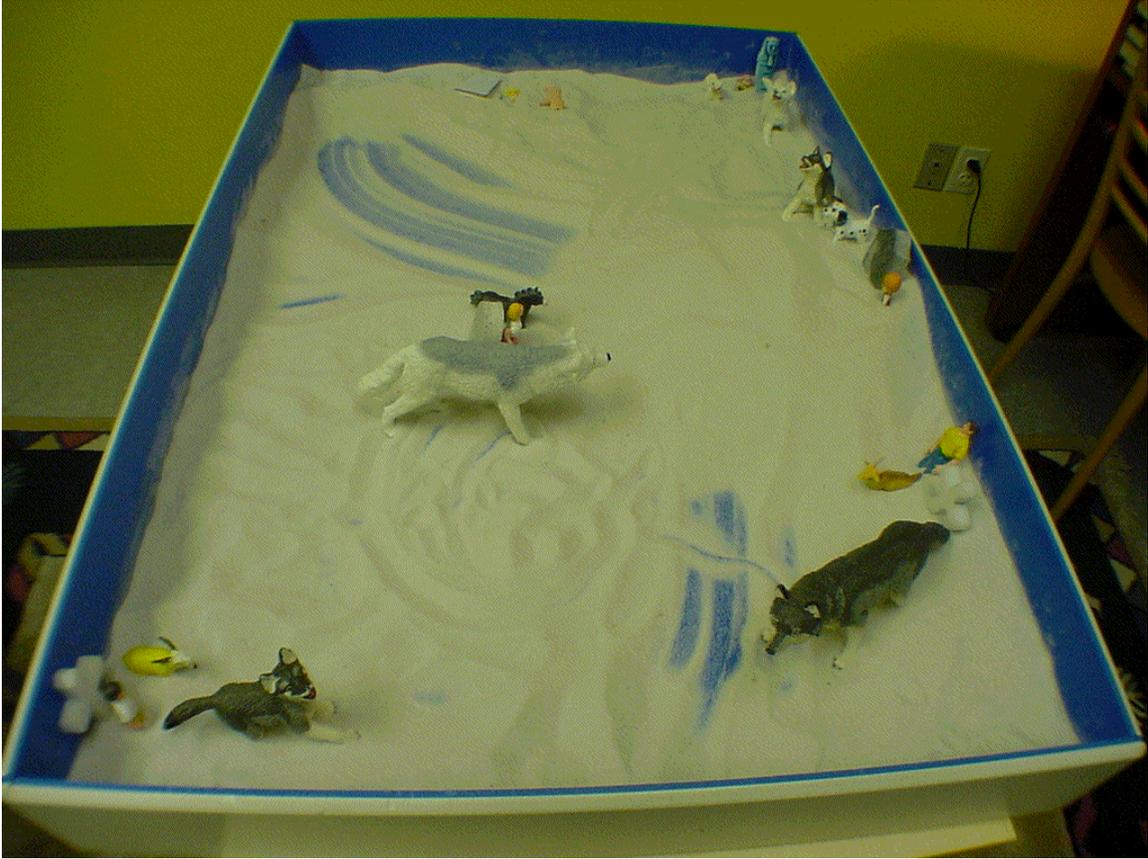
VITA FOR CYNTHIA R. MATHIS

ACADEMIC PREPARATION

Master of Science, Marriage and Family Therapy, Virginia Tech. Completed requirements for degree during May 2001. Acquired 56 graduate hours with a 3.97 G.P.A.; and 586 direct clinical hours serving families, couples, and individuals. Completed clinical internships at the three following locations:

- Two-year clinical internship at the Center for Family Services, Virginia Tech, Falls Church, Virginia.

- One-year clinical internship in the Abused Children's Treatment Services, Inova Kellar Center, Fairfax, Virginia.

- Five-month internship at Alternative House, Vienna, Virginia.

B.S. Family Studies 1998. University of Kentucky, Lexington, Kentucky.

RELATED VOLUNTEER EXPERIENCE

Internship, Family Care Center, Lexington, Kentucky, 1998.

RELATED WORK EXPERIENCE

Anger Management Facilitator, Department of Human Development, Virginia Tech, Falls Church, Virginia, 1999.

Graduate Assistant, Administration and Graduate Records, Virginia Tech, Falls Church, VA, 1998-2001.

Preschool Teacher, Country Day School, McLean, Virginia, 1999.

Director, YWCA Summer Camp, Lexington, Kentucky, 1997.

Childcare Assistant, University of Kentucky's Early Childhood Lab, 1995-1998.