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# **Playing for Real:**

## **Play therapy with children traumatised by maltreatment – a pilot study**

*A thesis presented in partial fulfilment  
of the requirement for the degree of  
Master of Science in Psychology  
at Massey University,  
Albany, New Zealand.*

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2002**

## **Abstract**

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The aim of the present study was to develop and pilot a play therapy manual for use with maltreated children presenting with trauma symptoms or post traumatic stress disorder. Four children (aged 6-8 years) with trauma symptoms and their caregivers participated in the study. Pre and post-treatment measures included a structured diagnostic interview with the children to determine PTSD diagnosis, parent report, teacher report, and child self-report measures. While some treatment gains were observed, these were most evident where there was greater PTSD symptomatology. The play therapy manual developed for the study appeared to allow the processing of trauma for the four children involved in the study, with children responding well to the therapeutic tools utilised. Findings offer preliminary support for manualised, trauma-specific play therapy intervention with maltreated children, with further research indicated to determine both effectiveness and efficacy.

## Acknowledgements

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Thanks to God, my mountain, source and strength

Thanks to my family and friends, the banks of the river, who hold me in  
check and provide guidance and support

Thanks to the children I have worked with, the stones and pebbles who  
provide the song of my journey...

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# Table of Contents

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<b>Abstract.....</b>	<b>ii</b>
<b>Acknowledgements.....</b>	<b>iii</b>
<b>Table of Contents .....</b>	<b>iv</b>
<b>List of Tables .....</b>	<b>vi</b>
<b>List of Figures.....</b>	<b>vii</b>
 <b>Outline of Thesis.....</b>	 <b>1</b>
 <b>Chapter One: Introduction .....</b>	 <b>2</b>
Overview .....	2
The Scientist-Practitioner Model .....	2
The Present Study .....	3
Summary .....	4
 <b>Chapter Two: Trauma.....</b>	 <b>5</b>
Overview .....	5
Child Maltreatment .....	5
Post Traumatic Stress Disorder.....	12
Summary .....	26
 <b>Chapter Three: Treatment.....</b>	 <b>27</b>
Overview .....	27
Play Therapy .....	27
Current Research.....	34
Treatment for maltreated children: .....	43
Summary .....	44
 <b>Chapter Four: Development of treatment manual .....</b>	 <b>46</b>
Overview .....	46
Rationale .....	46
The Present Study .....	47
Treatment Manual .....	48
Summary .....	50
 <b>Chapter Five: Method.....</b>	 <b>51</b>
Overview .....	51
Participants.....	51
Procedure .....	55
Measures .....	57
Summary .....	65

<b>Chapter Six: Results .....</b>	<b>66</b>
Overview.....	66
Diagnosis.....	66
Parent/Caregiver Measures .....	70
Child Measures .....	78
Therapy Process .....	81
Summary.....	98
 <b>Chapter Seven: Discussion .....</b>	 <b>99</b>
Overview.....	99
Summary of Findings.....	99
The Therapeutic Process .....	106
Strengths of the present study .....	108
Limitations of the present study.....	109
Issues and Complexities.....	111
Implications for clinical practice .....	113
Suggestions for future research.....	114
Summary.....	115
 <b>Closing Summary .....</b>	 <b>117</b>
 <b>References .....</b>	 <b>119</b>
 <b>Appendices .....</b>	 <b>136</b>
Appendix A: DSM-IV criteria for Post Traumatic Stress Disorder .....	137
Appendix B: Alternative PTSD criteria for children .....	139
Appendix C: Information Sheet for Caregivers .....	141
Appendix D: Information Sheet for Children .....	142
Appendix E: Consent form for Caregivers.....	143
Appendix F: Consent form for Children .....	144
Appendix G: Weekly Checklist for Children.....	145
Appendix H: Feelings Chart.....	146
Appendix I: Weekly Behaviour Report for Caregivers.....	147

## List of Tables

---

Table 1.1. Differences between research and clinic based therapy

Table 6.1. Post traumatic stress symptoms and resultant diagnoses as detailed in  
Children's Post Traumatic Stress Disorder Inventory

Table 6.2. Parent/Caregiver Report Measures at pre and post-treatment

Table 6.3. Teacher Report Form at pre and post-treatment

## List of Figures

---

- Fig.1.1. Interwoven strands of relevant literature pertaining to children
- Fig.6.1. Comparison of caregiver and teacher CBCL at pre and post-treatment for participant one
- Fig.6.2. Comparison of caregiver and teacher CBCL at pre and post-treatment for participant two
- Fig.6.3. Comparison of caregiver and teacher CBCL at pre and post-treatment for participant three
- Fig.6.4. Comparison of caregiver and teacher CBCL at pre and post-treatment for participant four
- Fig.6.5. Trauma Symptom Checklist for Children – pre-test only for participant one
- Fig.6.6. Trauma Symptom Checklist for Children – pre and post-test for participant two
- Fig.6.7. Trauma Symptom Checklist for Children – pre and post-test for participant three
- Fig.6.8. Trauma Symptom Checklist for Children – pre and post-test for participant four
- Fig.6.9. Weekly behaviour report for participant one
- Fig.6.10. Weekly behaviour report for participant three
- Fig.6.11. Weekly behaviour report for participant three
- Fig.6.12. Sand-tray process for participant one
- Fig.6.13. Sand-tray process for participant two
- Fig.6.14. Sand-tray process for participant three
- Fig.6.15. Sand-tray process for participant four

## **Outline of Thesis**

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This thesis presents a pilot study of a manual based play therapy intervention for children traumatised by maltreatment. Due to the volume of information, the thesis has been divided into seven chapters. Each chapter discusses a particular area of focus.

Chapters one to three, together form the introduction and literature review. The first chapter provides an overview of the philosophical underpinnings and guiding principles informing the study. Trauma, and the links between child maltreatment and post-traumatic stress disorder are discussed in chapter two. Chapter three outlines treatment, both in terms of current research regarding treatment of PTSD in children, and play therapy in particular. These two areas of research guide the play therapy manual developed and implemented by the researcher in this study, described in detail in chapter four.

The method utilised in the current study is presented in chapter five, including a description of participants, methodology, and psychometric measures used. Chapter six presents the results, via both pre and post-test measures, and anecdotal descriptions of the play therapy process in addressing trauma. Finally, chapter seven discusses the findings, including strengths, limitations, complexities, and implications for clinical practice and future research. In order to weave together these strands, an analogy of psychotherapy with maltreated children is offered in the form of a closing summary.

# Chapter One: Introduction

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## *Overview*

This chapter describes the scientist-practitioner model and how it informs both research and practice. Particular reference is made to the bridging of the practice-research gap by basing research in clinical practice. These two concepts are then linked in the presentation of the objectives of the present study.

## *The Scientist-Practitioner Model*

The aim of the scientist-practitioner model is to encourage clinicians to evaluate their interventions scientifically, and for researchers to interpret findings with an understanding of human complexity (Kendall, Flannery-Schroeder and Ford, 1999). The scientist-practitioner model thus allows for the marriage of both the 'art' and the 'science' of psychotherapy. One particular model of scientist practitioner inquiry, the single subject model, is foundational in linking science and practice, and can provide rich and useful information about the clients needs (Evans, 1997).

The present study is born out of clinical practice, the desire to ensure the best possible treatment for children, and awareness that much of what is currently practiced in the area of psychotherapy for maltreated children, namely play therapy, has yet to be empirically validated. As such, clinical work provides the impetus and inquiry for study, and research informs effective and ethical clinical practice. As Kendall et al. (1999; 332) comment, "a continuous dialectic of science and practice is needed to produce meaningful research capable of evaluating the efficacy and effectiveness of therapy."

While there has been much advance in psychotherapy outcome research, criticism has been offered in it's inadequacy in generalising to the real world clinical setting. Goldfried and Wolfe (1998) argue that clinical validity has been compromised by the 'medicalisation' of outcome research. They propose the need for greater

collaboration between clinician and researcher in order to bridge the gap between research and practice. Due to the difficulty in generalising research findings to real world settings, there is now increasing impetus for the development, validation, and transporting of effective treatments to clinical settings (Weiss, Catron, Harris, and Phung, 1999). Some of the differences between research and clinic based therapy are outlined in Table 1.1.

Research based therapy	Clinic based therapy
<ul style="list-style-type: none"> <li>• Clients recruited for treatment</li> <li>• Simple focal problems</li> <li>• Therapy addressing focal problems</li> <li>• Therapy reliant on trained techniques</li> <li>• Therapy guided by manuals and monitored for integrity</li> <li>• Therapy often undertaken by graduates with less clinical experience</li> </ul>	<ul style="list-style-type: none"> <li>• Clients may be involuntary</li> <li>• Often involves seriously disturbed clients with a range of problems</li> <li>• Therapy directed at a range of problems</li> <li>• Therapists not necessarily having training in all techniques used</li> <li>• Neither treatment manuals nor external monitoring of treatment integrity</li> <li>• Therapy often undertaken by trained and experienced clinicians</li> </ul>

Table 1.1. Differences between research and clinic based therapy (adapted from Wiesz, Weiss and Donenberg, 1992).

### ***The Present Study***

The key aim of this study was to bridge the research-practice gap as it pertains to play therapy with maltreated children. Play therapy is often the treatment of choice when working with maltreated children, despite limited empirical evidence regarding its effectiveness or efficacy. As such, clinical practice – that of play therapy with abused/neglected children, as it occurs ‘in the field’ was the impetus for the development of a play therapy manual in order to examine the continued use of this model. Inherent in this study is closer examination as to what constitutes ‘play therapy’ in clinical practice, and awareness that most clinicians utilise a variety of techniques when working with children.

In keeping with the scientist-practitioner model, a case study based design has been utilised in order to assess more fully the effectiveness of this particular play therapy program with four maltreated children with PTSD symptomatology. The present study examines and amalgamates the literature from three main areas pertaining to children; namely maltreatment; trauma or post-traumatic stress disorder (PTSD); and treatment. Visual representation of these three strands is provided in Figure 1.2.

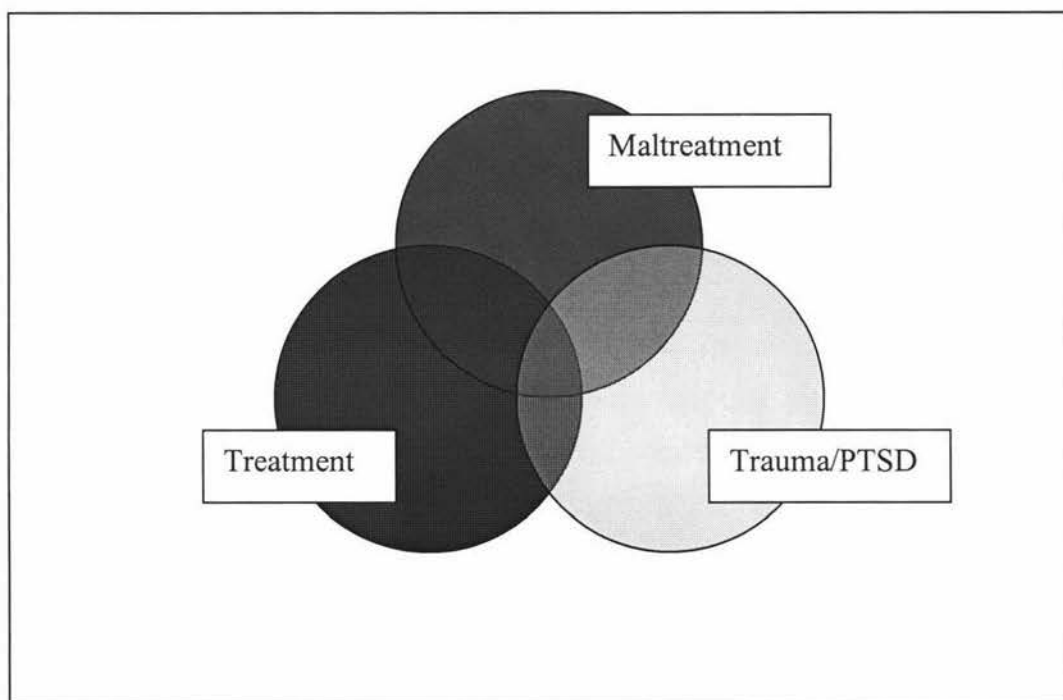


Fig 1.2. Interwoven strands of relevant literature pertaining to children.

### ***Summary***

In summary the present study is guided by the scientist-practitioner model of inquiry and rooted in clinical practice. As such, both the 'clinical' and 'research' elements of this study are informed by current research and practice guidelines as they pertain to the treatment of traumatised children. Further, the scientist-practitioner model behoves a mind open to discovery and the striving to attain treatment that is both effective and efficacious. It is hoped that this study will provide a springboard for future study and add both colour and depth to the treatment outcome literature.



## Chapter Two: Trauma

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### *Overview*

The word ‘trauma’ comes from the Greek word meaning ‘wound’, and refers to ‘a powerful shock that may have long-lasting effects’ (Collins, 1989). As such, trauma can occur via a number of sources, and have physical, mental, emotional and social repercussions. The present chapter overviews the literature pertaining to trauma, in particular to Post Traumatic Stress Disorder (PTSD) as it relates to children who have been maltreated.

### *Child Maltreatment*

Within New Zealand the care and protection of children and young people is undertaken by the statutory agency Child, Youth and Family. As such, guidelines pertaining to the maltreatment of children are informed by legal definitions and requirements for the safety and wellbeing of children. Most legal definitions are contained within Section 14 of the Children, Young Persons and Their Families Act (1989), which covers physical, emotional, and sexual abuse, alongside serious deprivation, impairment in the development of physical, mental or emotional wellbeing, abandonment, and parents being unable or unwilling to care for the child.

### **Definition**

Definitions regarding child abuse abound, and need to take into account not only operational definitions, but also relevant legislation,\*<sup>1</sup> alongside contextual factors including culture, ethnicity, social expectations, and individual rights (McDowell, 1997). The Ministry of Education (Wellington Learning Media, 1992, as cited in McDowell, 1997) define four types of child abuse:

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<sup>1</sup> Such as the Children, Young Person’s and Their Families Act (1989), and the Domestic Violence Act, (1996).

- Physical abuse, where non-accidental injuries occur to a child such as burns, bruising and broken bones.
- Sexual abuse, which is the use of children for the sexual gratification of someone who takes advantage of their power and/or the children's trust.
- Neglect, which is to deprive children of necessities such as food, shelter, supervision appropriate to their age, and essential physical and medical care.
- Emotional abuse, where the attitudes and behaviours of adults severely affect a child's emotional and physical development.

The witnessing of domestic violence is now considered to be abusive to the child, and may place the child at greater risk of direct abuse (Lehmann, 2000; Millen, 1994; Robertson and Busch, 1994). McCloskey and Walker (2000) found a background of abuse, especially children exposed to family violence, increased the risk of PTSD and other disorders. While physical abuse has received relatively little attention comparative to sexual abuse, evidence suggests that physical abuse is just as traumatic, with many long-term consequences (Stevenson, 1999).

Emotional abuse and neglect is an under-recognised, but common, form of maltreatment (Glaser, 2002). Neglect, particularly in the early years of life has severe effects on cognitive, socia-emotional and behavioural development (Hildyard & Wolfe, 2002). Psychological or emotional abuse often underpins all forms of child maltreatment, with many forms of abuse occurring simultaneously (Veltman & Browne, 2001). To encompass all forms of abuse and neglect, the term maltreatment will be referred to throughout this thesis.

## **Prevalence**

In the United States an estimated one in every three to four girls, and one in every seven to eight boys will be sexually assaulted before the age of 18 years. However, actual occurrence rates are likely to be higher than these estimates as many cases go unrecognised and unreported (Kaplan and Sadock, 1998).

In New Zealand, Child, Youth and Family receive an average of 20,000 care and protection notifications requiring further investigation each year. Of these, around 3,000 are substantiated regarding some form of abuse or neglect (Barnardos, 2001). Data for the year 2000, revealed that the rate of abuse or neglect for children aged 5-9 was 7.3 per 1000, with Maori children more likely to be assessed as abused and neglected than non-Maori (12.0 and 5.3 per 1000, respectively; Ministry of Social Policy, 2001).

Findings of completed Child, Youth and Family investigations in 1998/99 reported 8% physical abuse, 6.7% sexual abuse, 6.9% emotional abuse, and 11% neglect. Of those investigated a further 46.3% found no evidence of abuse or neglect (Ministry of Social Policy, 2000).

### **Maltreatment in context**

Abused children are a heterogeneous population, differing widely in type and intensity of symptoms and level of functional impairment. Child abuse occurs within a familial, community, and cultural context. The child's experience of abuse cannot be isolated from these contextual factors. Difficulties arise ascertaining whether the traumatic effects found in maltreated children are due to the abuse experience itself, or to prolonged exposure to a generally dysfunctional environment (James & Menne, 2001). Furthermore, removal from a parent's care and loss of the primary attachment relationship can also be as, or more traumatising to a child than the abuse itself (James, 1994).

For many children, maltreatment incorporates different forms of abuse, across time, and often by different perpetrators. Rosenberg and Rossman (1998) identify the need to consider multiple-victimization of children. In particular multiple victimization impacts the development of social and emotional regulation. However, they state it is unclear how family environments, attachment and nurturance may influence this development (Trickett, 1998). Further, some postulate that different forms of abuse may require different forms of intervention, particularly when considering the impact of psychological or emotional abuse (Glaser, 2002).

## **Risk Factors**

Various studies have investigated risk factors for child abuse and neglect in recent years. Findings can be categorised into child, parent, and parent/child relationship (McDowell, 1997), with familial factors having a significant effect, particularly on child sexual abuse (Lambie, 1997). Traumatic experience interacts with child and family factors in the development of PTSD, particularly where the trauma threatens family integrity (Silva et al, 2000). Further, parenting stress has been found to demonstrate a positive correlation with child abuse potential, particularly when combined with anger expression (Rodriguez and Green, 1997).

The Christchurch Health and Development Study (CHDS), a longitudinal study of a birth cohort of 1,265 children born in Christchurch in the 1970's revealed that at-risk children and families evidenced an accumulation of adverse conditions (single parenthood, sexual abuse, physical abuse, and family violence), which combined to increase the likelihood of outcomes such as academic underachievement, conduct difficulties, juvenile crime, youth suicide, and other psychosocial problems (Fergusson, 1998), substance abuse and mental health problems (Fergusson and Lynskey, 1997).

De Bellis (2001) offers a developmental traumatology model to account for the intergenerational nature of maltreatment. PTSD symptoms may be manifest through a number of disorders and developmental stages, including, attachment disorder, internalising disorders, externalising disorders and cognitive/learning disorders, then later, conduct disorder, alcohol and drug abuse, personality disorders, and increased risk of maltreating own children.

## **Effects of child maltreatment**

The effects of maltreatment are many and varied, having both short and long-term consequences. Childhood maltreatment may affect behavioural, social, cognitive and emotional repercussions, with particular risk for depression, post-traumatic stress disorder, relationship difficulties and negative beliefs and attitudes (Kendall-Tackett, 2002; Mullen, Martin, Anderson, Romans & Herbison, 1996).

An overview of common short-term outcomes found in maltreated children is outlined in Fig 2.1.

Sexual abuse	Problems or difficulties include: low self esteem, depression, anxiety, guilt, learning difficulties, sexual promiscuity or inappropriate sexual behaviour, runaway behaviour, somatic complaints, regressive behaviours, phobias, nightmares, self-destructive behaviours, impaired learning and academic achievement.
Physical abuse	Problems and difficulties include: aggression towards peers and adults, difficulty with peers, difficulty empathising with others, learned helplessness, ineffectiveness, anxiety, depression, feelings of worthlessness, low self-esteem, internalising problems, externalising behaviour problems, negative self-perceptions, poor performance in language and intelligence measures, conduct disorder, opposition and defiance.
Neglect	Problems and difficulties include: difficulty trusting others, social skills deficits, helplessness, low self-esteem, impaired cognitive development/academic achievement, the tendency to act as caretaker, anxiety, depression, irritability, failure to thrive, anxious attachment, fear or distrust, feelings of inferiority, and withdrawal.
Emotional abuse	Problems and difficulties include: limited frustration tolerance, poor impulse control, internalisation or externalisation of anger, sadness, depression, psychosomatic complaints, school absences, delinquent behaviour, non-compliance, attention difficulties, and aggression.

Fig 2.1. The impact of maltreatment on children (adapted from Cattananch, 1992; Glaser, 2002; Hildyard & Wolfe, 2002; Kendall-Tackett, Williams, and Finkelhor, 1993; Pelcovitz, Kaplan, Goldenberg, Mandel, Lehane, & Guarrera, 1994; Mablango, 2002; Veltman and Browne, 2001).

*Neurobiology and Development*

Recent developments in the field of child psychopathology have documented the effects of maltreatment on both child development and neurobiology. Exposure to intra-familial violence and chronic trauma results in pervasive psychological and biological deficits (Streeck-Fischer and van der Kolk, 2000). Neurobiological studies have revealed the relationship between child maltreatment, the stress response in the brain, and the subsequent effect on emotional, psychological and behavioural difficulties observed in abused and neglected children (Glaser, 2000).

Neurobiologic sequelae of child PTSD include the effects of early trauma on the development of the brain, dysregulation of the catecholamine systems (including startle response), and dysregulation of the HPA axis (Lipschitz, Rasmussen & Southwick, 1998). Child abuse and neglect and PTSD symptoms in children may thus influence the alteration of catecholamine and HPA axis, changes in brain metabolism, resulting in adverse effects on brain development and compromised cognitive and psychosocial outcomes (De Bellis, 2001).

The brain develops in a sequential and hierarchical fashion. As such, the brain of an infant or young child is more malleable to experience. Disruption during critical or sensitive periods of brain development may lead to abnormalities or deficits in development. The disruption of critical cues can result from lack of sensory experiences during critical periods, or abnormal activation of neuronal activity due to maltreatment (Perry, Pollard, Blakley, Baker and Vigilante, 1995). While the brain exhibits much plasticity in young life, the chronic nature of abuse and neglect may negate the potential for development and change in these children, which indicates the importance of early intervention (Glaser, 2000).

### *Mental health problems*

Childhood maltreatment is a significant risk factor in the development of mental health problems in childhood, adolescence, and adulthood (Starr and Wolfe, 1991). Psychiatric disturbances in abused children include anxiety, aggression, paranoid ideation, PTSD, depressive disorders, and an increased risk of suicidal behaviour (Kaplan and Sadock, 1998, Putnam, 1997), dissociative identity disorders and borderline personality disorder (Putnam, 1997).

Paolucci, Genius and Violato (2001), in a meta-analysis of the published research on the effects of child sexual abuse found clear links between sexual abuse and both short and long term effects on development. The major findings of the study were a substantial effect of child sexual abuse on PTSD ( $d = .40$ ), depression ( $d = .44$ ), suicide ( $d = .44$ ), sexual promiscuity ( $d = .29$ ), sexual perpetration ( $d = .16$ ), and academic achievement ( $d = .19$ ). Eth and Pynoos, (1985, as cited in James, 1989), found PTSD the most common diagnosed disorder in children who had been sexually abused, and the fourth most common in children who had been



physically abused, compared with ranking seventh for children who had witnessed disasters.

### *Learning difficulties*

Maltreatment of children has been shown to result in delayed language or cognitive development, low IQ, and poor school performance (Veltman and Browne, 2001). The witnessing of domestic violence can also have an effect on intellectual functioning, particularly verbal abilities (Huth-Bocks, Levendosky, and Semel, 2001). A study by Beers & De Bellis (2002), supported cognitive differences between children with and without maltreatment-related PTSD. The maltreated children in their sample exhibited difficulty with attention, abstract reasoning, executive function, distractibility, and memory.

### *Longer term risks*

Alongside the impact that maltreatment has on children in their school years, there are long-term consequences of abuse. In an examination of the long-term consequences of physical abuse, Malinosky-Rummell and Hansen (1993) found that aggressive and violent behaviour, criminal behaviour, substance abuse, self-injurious and suicidal behaviour, emotional problems, interpersonal problems and academic and vocational difficulties were common. Further, they state, it is estimated that approximately 30% of physically abused or neglected individuals go on to abuse children of their own, thus perpetuating the 'cycle of violence'.

In a longitudinal study in Christchurch, New Zealand, young people exposed to harsh or abusive treatment during childhood were at increased risk for juvenile offending, substance abuse and mental health problems (Fergusson and Lynskey, 1997). For sexually abused children there was increased risk of psychiatric disorder and adjustment difficulty in young adulthood. However, these were mediated by the quality of peer and family relationships (Lynskey and Fergusson, 1997).

In summary, childhood maltreatment may result in a range of mental health, social, behavioural, and cognitive difficulties, of which post-traumatic stress disorder is one possibility. While there have been a number of studies demonstrating links

between child sexual abuse and the development of PTSD (e.g. Briggs & Joyce, 1997; King, 2000; Paolucci, Genius and Violato, 2001), there is less information regarding other forms of maltreatment, although studies have emerged indicating that witnessing physical abuse and domestic violence may predict severity of PTSD (Silva et al, 2000).

## ***Post Traumatic Stress Disorder***

### **History**

The notion of PTSD has existed for some time, and was born out of the experience of soldiers (Kaplan and Sadock, 1998). PTSD as a diagnostic entity was not related to children and adolescents until the publication of DSM-III-R (APA, 1987). Prior to this time, children thought to spontaneously recover from trauma, and that symptoms mimicked those of adults. Currently PTSD is viewed as a potentially serious disorder in children with effects on biological, psychological and social development. DSM-IV (APA, 1994) outlines criteria for PTSD, with some acknowledgement of the differential experience for children.

### **Diagnosis**

Posttraumatic stress is defined as a typical set of symptoms that develop after a person experiences “an extreme traumatic stressor” (Kaplan and Sadock, 1998). \*  
Diagnosis of PTSD requires exposure to a traumatic event whereby the person experienced or witnessed threat of death or injury to the self or others, and where the person’s response involved fear, helplessness or horror. Secondly, in response to the traumatic experience a cluster of three types of symptoms must occur: re-experiencing, avoidance or numbing and hyper-arousal. Further, the duration of such symptoms is required to be greater than one month, and result in significant distress or impairment in functioning. Specification is also required as to whether the PTSD is acute (duration of less than 3 months), chronic (duration of symptoms 3 months or more), or delayed onset (onset of symptoms at least 6 months after stressor) (APA, 1994). For full diagnostic criteria see Appendix A.



## **Subtypes**

Terr (1991) conceptualised a framework of PTSD determined by the type of trauma experienced. Type I, or 'sudden blow' trauma, such as a motor vehicle accident or sniper attack result in classic DSM symptoms of reexperiencing, avoidance and increased arousal. Type II traumas, such as ongoing physical or sexual abuse, resulting in denial, numbing, dissociation, and rage. Such differentiations have been found particularly relevant with sexually abused children (Tremblay, Hebert, & Piche, 2000).

Famularo, Fenton, Kinsherff, Avoub and Barnum, (1994) describe differences between acute and chronic PTSD; with acute having a predominance of sleep difficulties, physiological hyper-arousal and re-experiencing, while chronic had more dissociation, restricted affect, sadness and detachment. Such findings may reflect some associations between the type of symptomatology and the type of trauma (i.e sudden versus ongoing).

## *Complex PTSD*

"Complex" PTSD (CP), or Disorders of Extreme Stress (DES), have also been proposed in order to account for the inadequacy of the definition of PTSD symptoms for some clients. CP/DES is believed to more adequately characterise those who have been sexually abused as children or multiply maltreated, and is suggested to offer a more developmentally appropriate framework for assessment and treatment (Hall, 1999; Zlotnick et al, 1996), and such criteria have been applied to young children who have been seriously abused (Hall, 1999). However, at present, DES-NOS is included in DSM-IV as associated symptoms rather than an additional category (APA, 1994).

## **Diagnosis in maltreated children**

While children may suffer from PTSD, symptoms vary depending on the developmental stage of the child. In general as children mature, symptoms reflect adult-like PTSD symptoms. Children's initial response to trauma is often characterised by physiological and behavioural hyperarousal, and when the trauma

is ongoing the response may become complicated by dissociation (Perry et al 1995).

DSM-IV outlines specific PTSD criteria that may be evidenced in children, such as disorganised or agitated behaviour, repetitive play, frightening dreams, and trauma specific re-enactment (APA, 1994). Children who suffer PTSD may experience any of the following: repetitive, intrusive thoughts, vivid flashbacks, sleep disturbances, fears of the dark, nightmares, night waking, separation difficulties, anger and irritability, difficulty talking to parents and peers, difficulty concentrating, memory problems, alertness to danger, a sense of fragility of life, changed priorities and values, fears associated with a specific event, avoidance of situations associated with trauma, guilt, depression, panic attacks (AACAP, 1998; Davis & Siegel, 2000; Herbert, 1996; Perrin, Smith and Yule, 2000).

Very young children may present with relatively few symptoms due to limited capacity for verbal description (Scheeringa et al, 1995). Infants, toddlers, and preschool children may thus present with generalised anxiety symptoms (fears, separation, etc), avoidance of situations, sleep disturbance, and preoccupation with words that may or may not have links to traumatic events (AACAP, 1998).

In a study involving the assessment of PTSD in 59 children aged 7-14, Carrion, Weems, Ray, & Reiss (2002) found 24% of the children studied met full diagnostic criteria. Full PTSD diagnosis was most strongly associated with detachment from others, hypervigilance and exaggerated startle response, for both frequency and intensity of symptoms. Overall impairment was most strongly associated with distressing recollection, distressing dreams and the inability to recall important aspects of the event. In examination of the different symptom clusters, the most common cluster was re-experiencing (76% meeting diagnostic criteria), followed by avoidance/numbing (51%) and hyperarousal (46%).

A study of abused children by Wolfe, Sas, & Werkle (1994) found 80% met re-experiencing criteria, 64.4% avoidant criteria and 66.7 % hyperarousal criteria. Overall 48.9% fulfilled DSM criteria for PTSD. The PTSD group contained more females, and older children, and were more likely to have been abused for a year or longer. Non-PTSD children were more likely to have suffered isolated instances of abuse. Abuse related variables of duration, severity, coercion, and relationship to abuser accounted for 26.9% of the variance.

### **Limitations of PTSD diagnosis in children**

The applicability of the DSM based PTSD trauma model to maltreated children has proven more problematic than to other types of trauma (McNally, 1993, as cited in Putnam, 1997). Childhood physical and sexual abuse is more complicated to study than other traumas, as abuse often occurs over long periods of time and is exacerbated by other family factors such as poverty, neglect, alcoholism and drug abuse, disrupting normal development (Davis and Siegel, 2000).

Many PTSD trauma models do not account for many of the symptoms and behaviours exhibited in maltreated children such as depression, aggression, hypersexuality, suicide, self-mutilation, problems with affect regulation, somatisation, impulsivity, hyperactivity/attentional problems, and low self esteem (Putnam, 1997).

Putnam (1997) states that the majority of maltreated children exhibit only partial forms of PTSD, with re-experiencing and avoidant symptoms common (McNally, 1993, as cited in Putnam, 1997). Types of symptoms may vary depending on the type of abuse experienced (Deblinger, McLeer, Atkins, Ralphe & Foa 1989), and the age of the child (Street & Sibert, 1998), accounting for the failure of some younger children to reach diagnostic criteria. Controversy exists over the number of symptoms required to diagnose PTSD, and the consideration of PTSD as a discrete disorder. Cohen, Berliner and March (2000) believe current criteria may not be sufficiently sensitive to developmental issues, particularly in younger children.

Such discrepancy may be due to inadequate structured interviews or assessment techniques for children, alongside the failure to substitute developmentally relevant PTSD symptoms for adult symptoms. While this was partly addressed in DSM- IV, there are significant age-specific problems with the current criteria (APA, 1994). Many criteria are developmentally inappropriate or difficult to evaluate in children. As such, Putnam (1997) confers that PTSD is better conceptualised as dimensional, rather than categorical in nature.

In light of these concerns, Scheeringa et al, (1995) offer alternative criteria for children less than 4 years of age. These alternative criteria (Appendix B) require fewer symptoms for diagnosis, and disturbance of only one-month duration without causing a significant impairment in functioning. Such alternative criteria appear to show greater validity in measuring PTSD in young children (Scheeringa, Peebles, Cook & Zeanah, 2001). While such criteria are outlined for preschoolers, they may prove suitable for older children if consideration is given to research indicating the possible impact of maltreatment on cognitive, emotional, and social development.

Carrion et al. (2002) suggest the need to distinguish between the frequency and intensity of symptoms. In their study, children with subthreshold criteria did not differ significantly from children meeting all three criteria with regard to impairment and distress. As such, they suggest that rather than seeking a threshold number of symptoms, a more precise diagnosis of PTSD may be gained by evaluating the intensity of symptoms and their relation to functional impairment, alongside developmental modifications to clusters C and D.

### **Aetiology, course and development**

In children, PTSD may result due to war, sexual or physical abuse, the witnessing of community or domestic violence, surviving natural disaster, witnessing or loss of sibling or family member to accidental death or murder, and witnessing or surviving motor vehicle accidents (Davis and Siegel, 2000; Herbert, 1996; Saigh, Green and Korol, 1996).

Not everyone exposed to a trauma develops PTSD. Factors contributing to the development of PTSD include: trauma related factors (type of trauma, exposure, magnitude, amount, frequency, severity; proximity); and individual and social factors such as age/developmental level, gender, cognitive ability, political circumstances, social and cultural factors, family factors, and prior traumatisation (Pfefferbaum, 1997; Yule & Canterbury, 1994). A review of 25 studies by Foy, Madvig, Pynoos & Camilleri, (1996) indicated that three factors consistently mediated the development of PTSD in children: 1) the severity of trauma exposure, 2) trauma related parental distress, and 3) proximity to the traumatic event.

The interaction of risk factors and the severity of trauma appear to influence the development of PTSD, with resilience, coping skills, and the availability of social support acting as possible protective factors (Davis & Siegel, 2002). Such findings regarding the role of parental/family factors highlight the importance of the relational context, in particular, the parent-child dynamic, in both the development and maintenance of PTSD in children (Scheeringa & Zeanah, 2001), offering pivotal information for the assessment and treatment of maltreated children.

Although studies indicate some children spontaneously recover from PTSD, evidence suggests that symptoms can persist for many years. Studies investigating abuse, war, natural disaster and accidents indicate that while PTSD symptoms spontaneously remit in some children, they persist for long periods of time in a substantial portion of children (AACAP, 1998). In a study by Famularo, Fenton, Augustyn, & Zuckerman (1996), between 32.7% and 50% of maltreated children had persistent PTSD symptoms up to two years following the trauma.

### **Prevalence of PTSD in maltreated children**

Estimations regarding the prevalence of PTSD in abused child vary considerably, particularly in relation to the nature and severity of the traumatic event, although no epidemiologic studies have been undertaken to date (Yule, 2001). In a longitudinal study examining potential traumatic events in childhood, Costello, Erkanli, Fairbank and Angold (2002) found 25% of children experienced at least one 'high magnitude' stressor (such as abuse, violence, serious illness or accident),

by the age of 16, and 33% experienced a 'low magnitude' event (such as school/friend changes) in a three month period. The likelihood of exposure to traumatic events increased with vulnerability factors (such as family mental illness, poverty, and the experience of other traumas).

Glod and Teicher, (1996) found 68% of their sample met criteria for PTSD, with the higher incidence contributed to by cases of documented abuse, hospitalised patients, a combination of physical and sexual abuse, and children who were young and abused early in life. Deblinger, McLeer, Atkins, Ralphe and Foa (1989) examined the prevalence of PTSD symptoms among physically abused, sexually abused and non-abused children. Findings revealed that 20.7% of sexually abused, 6.9% of physically abused and 10.3 % of non-abused children met criteria for PTSD.

For maltreated children in foster care, Dubner and Motta (1999) found 64% of sexually abused children, 42% of physically abused children, and 18% of non-abused children met criteria for PTSD. The high rates in the non-abused sample were attributed to witnessing family violence or violent crimes. Ackerman, Newton, McPherson, Jones and Dykman (1998) found that 34% of 7-13 year old children they studied met criteria for PTSD, with those who had been both physically and sexually abused, or abused from a young age were at greatest risk for psychiatric disturbance.

Similar rates have been found in adults abused as children. For example, Widom (1999) found an increased risk for PTSD not only in physically or sexually abused children, but also in those neglected. Approximately a third of each type of abuse met criteria for PTSD (sexual abuse 37.5%, physical abuse 32.7%, and neglect 30.6%). Widom concluded that victims of abuse and neglect are at increased risk for developing PTSD, with family, individual, and lifestyle variables also contributing. Rodriguez, Ryan, Kemp and Foy (1997) in a comparison of PTSD symptoms in abused and non-abused women, found high rates of current (86.7%), and lifetime (97.8%), PTSD for those who had experienced child sexual abuse. Higher levels of exposure, alongside the experience of both sexual and physical



abuse (89% of the sample), accounted for higher levels of PTSD symptoms and intensity.

### **Gender, age, family factors, ethnicity and culture**

Some studies have indicated that girls may develop more severe and long-lasting PTSD symptoms, while boys are more likely to be exposed to trauma (AACAP, 1998). Females may be up to five times more at risk for the development of PTSD, although this may be accounted for by being more likely to report symptoms (Davis & Siegel, 2002). Boys tend to express disturbance through acting out or externalizing behaviours, girls through inward behaviour such as depression or anxiety (Davis and Siegel).

Age at the time of trauma may mediate the development of PTSD. In a meta-analysis comprising children who had experienced trauma, (Fletcher, 1996, as cited in Salmon & Bryant, 2002), 35% of children met criteria for PTSD following a range of traumas, with no significant difference across developmental levels (39% under 7 years, 33% 6-12, and 27% over 12). However, maltreated children with PTSD appear to have an earlier average age of initial abuse (Famularo, Fenton, Kinscherff, Ayoub, & Barnum, 1994; Glod and Teicher, 1996). Davidson and Smith (1990, as cited in Davis & Siegel, 2002) found that if traumatic events are experienced before the age of 11 years, PTSD is three times more likely to develop. Thus children and adolescents may be at higher risk for developing the disorder.

A number of studies have found that familial support mitigates the development of PTSD in children. Conversely, parental distress about the trauma, and/or the presence of parental psychiatric disorder predicted higher levels of PTSD in children (AACAP, 1998). Parent's reaction to a traumatic event may act as an important mediator. When adults appear to be calm and in control, children's fears are alleviated (March & Amaya-Jackson, 1995, as cited in Davis & Siegel, 2002).

PTSD appears to occur across ethnic and cultural backgrounds, although cultural factors may affect how PTSD is manifested (AACAP, 1998). However, as data outlined earlier reveals, maltreatment may be assessed more frequently in Maori children within NZ, as such consideration of possible higher rates of PTSD within this population must be considered.

### **Co-morbidity**

Rates of co-morbidity with PTSD are quite high, and include specific fears and phobias, social phobias, panic attacks, behaviour disorders, (Goenjian et al. 1995), anxiety and mood disorders (Ackerman et al, 1998; Goenjian et al, 1995) substance abuse, separation anxiety, Attention Deficit Hyperactivity Disorder, (AACAP, 1998), and borderline personality disorder (Putnam, 1997). McCloskey and Walker (2000), found trauma had a global and diffuse impact on functioning, with many co-morbid conditions being found, most notably phobias and separation anxiety. Friedman (2000) outlined the prevalence of co-morbid disorders as follows: affective disorders (26-65%), anxiety disorders (30-60%), alcohol and drug abuse (60-80%), and personality disorders (40-60%). Similarly Carrion et al, (2002) found co-morbid diagnoses included mood disorders (23%), externalising disorders (17%), and anxiety (48%).

### **Differential Diagnosis**

Considerations in the diagnosis of PTSD include the possibility of head injury during trauma, or other organic causes such as epilepsy, alcohol use, or substance related disorders. Generally PTSD can be differentiated from other disorders by asking about the stressor and subsequent symptoms (Kaplan and Sadock, 1998).

PTSD may be mistaken for Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD). Studies demonstrating a strong association between PTSD and ADHD (Famularo et al, 1994; Glod and Teicher, 1996; McLeer et al, 1994), suggest that abused children with PTSD may have an ADHD like condition that differs from true ADHD. This has implications for the assessment and treatment of maltreated children with



PTSD and the possibility that many children who exhibit ADHD like symptoms being at risk of misdiagnosis. Children with chronic PTSD may display temper tantrums, school refusal, parental defiance, hostility and aggression. Often these reflect high levels of irritability, over-sensitivity and extreme avoidance behaviours (Perrin, Smith & Yule, 2000).

Anxiety disorders are also common. Some children who have experienced a traumatic event may show anxiety symptoms related to the event, but no re-experiencing symptoms, and may meet criteria for other disorders (i.e. specific phobia). Difficulty may arise where the focus of an anxiety problem is a particular aspect of the trauma that has generalised to other situations (Perrin et al, 2000).

Alternative diagnostic considerations include Adjustment Disorder or Acute Stress Disorder. To meet criteria for PTSD the stressor must be of an extreme nature. Where a child has experienced a traumatic event, but not the required number of PTSD symptoms, an Adjustment Disorder may be the correct diagnosis. When the child has met both stressor and symptom criteria for PTSD, but the symptoms developed and resolved within one month of the event, the proper diagnosis is Acute Stress Disorder (Perrin et al, 2000).

Other possible considerations in assessing maltreated children are Reactive Attachment Disorder (RAD) and Separation Anxiety Disorder. These may be manifest where maltreatment has occurred within the family unit, or where children have been removed from home and placed in care. Presentation of RAD or Separation Anxiety Disorder may mask or complicate other trauma symptoms.

### **Further considerations**

Three key considerations exist when working with young maltreated children: the impact of developmental stage and cognitive capacity; the influence of attachment; and the possibility of dissociation.

### *Developmental stages in memory, language, and cognition*

Developmental differences in children include the ability to encode, understand, explain, and resolve trauma (Gaensbauer, 2000; Salmon & Bryant, 2002). While immaturity in these areas may protect children from negative symptoms, it may also result in diminished means of coping with trauma. Talking with adults can (a) reinstate the experience in memory and prevent forgetting (b) help the child to appraise and interpret the experience, (c) correct misconceptions, (d) help the child manage or regulate emotions, (e) provide information about coping strategies and facilitate their enactment (Salmon and Bryant). Thus, traumatic experiences in a preverbal child may later be re-experienced and reintegrated at each developmental level (Varkas, 1998).

While memory of trauma in children younger than three years of age is often fragmentary, children over three are able to give reasonably coherent accounts (Fivush, 1998). However, younger children are more susceptible to suggestion, and although memories are sparser than older children they do tend to be just as accurate. Of importance for many maltreated children, is that repeated experiences tend to result in more general and less detailed memories (Fivush).

### *Attachment*

Children's interaction with the world is primarily governed by the quality of their relationships with their parents. Attachment, according to Bowlby (1969), is a biologically based bond with a caregiver, with attachment behaviour ensuring proximity to the caregiver, particularly in times of distress. Children's attachment behaviour can be categorised into four categories, secure, resistant, avoidant, and disorganised. Securely attached children have an internal working model of caregivers as consistent, supportive in times of stress, attuned to their needs, and demonstrating reciprocity. Insecurely attached children operate from the assumption that relationships are unpredictable, punitive and lacking reciprocity.

Trauma related attachment problems occur whereby the source of danger and protection reside in one person (James, 1994). Thus, early experiences with the attachment figure allow the child to develop expectations about their, and other's role in relationships. As such, maltreated children may have problems forming

relationships with peers, partners, and their own children, perhaps forming the basis of the intergenerational transmission of violence (Morton and Browne, 1998).

The capacity to form relationships is related to specific organization and function of the brain. The systems in the brain that allow the formation and maintenance of emotional relationships are formed in the first years of life. Experiences during this vulnerable period of life are critical in the capacity to form and maintain healthy relationships. The brain systems responsible for healthy relationships will not develop optimally if the right experiences do not occur at the right times. 'Windows of opportunity' occur during the first three years of life. During these critical periods, bonding experiences must be present for the brain systems responsible for attachment to develop normally (Perry, Runyan and Sturges, 1998).

Research examining the relationship between abuse and attachment has focused largely on neglect and physical abuse. Insecure attachment has been found to predominate in these children. Successful intervention necessitates the enhancement of attachment security both in the therapeutic relationship, and with the child's current caregivers (Bacon and Richardson, 2001). An attachment based model of intervention focuses on the role of the therapist in providing a secure base from which both children and carers can explore new ways of relating (Pearce and Pezzot-Pearce, 1994), including modelling sensitive attuned care-giving (Bacon and Richardson, 2001).

### *Dissociation*

Dissociation is defined as a 'disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment' (APA, 1994, p 477). Behaviour reflective of dissociation in children includes: unusual forgetfulness, a poor sense of time, difficulty learning from experience, frequent daydreaming or trance states, sleepwalking, vivid imaginary companions, and abrupt changes in outward manner, knowledge, or age-appropriate behaviour (Putnam, 1993; Putman, Helmers, and Trickett, 1993).

In young children the development of a sense of self and the capacity to function independently is a key feature of early development. Progress extends through the development of a secure attachment to caregivers, autonomous self-development, and effective peer relationships. Maltreatment disrupts the normal process of development, rendering achievement of the next stage difficult or impossible (Jones, 2001). Dissociation may occur as a normal reaction to trauma through becoming part of an internal schema, through parental reinforcement of behaviour, or where part of the self is split off before reaching the developmental stage of self-integration (McElroy, 1992).

Studies examining the prevalence of dissociative symptoms among maltreated children vary, from 19% to 73% (Silberg, 2000). Perry, Pollard, Blakely, Baker and Vigilante, (1995) in studying severely maltreated children, found 65% of sexually abused girls were above the clinical cut-off score for dissociative pathology as rated by the Child Dissociative Checklist. In a study examining dissociation in maltreated and non-maltreated children, Macfie, Cicchetti, and Toth (2001) found sexual abuse, physical abuse, and neglect all implicated in the development of dissociation in preschool children. In this study dissociation was more common where there was physical abuse, high severity, extended chronicity, and the experience of more than one form of maltreatment. Thus, although dissociative disorders are relatively uncommon in children, dissociative symptoms may be observed in abused and maltreated children (Silberg, 2000).

Assessment of dissociation in children should include an evaluation of the child's functioning, family functioning, and interview with the child about imaginary friends, auditory and visual hallucinations, and the use of measures such as the Child Dissociative Checklist (Putnam et al., 1993; Putnam and Peterson, 1994). Intervention requires assistance to the child in integrating a sense of self through ending the maltreatment, and the provision of adequate care-giving, and the development of a secure attachment (Macfie, Cichetti and Toth, 2001).

#### *Relationship between attachment and dissociation:*

The relationship between dissociation and attachment is a growing focus in clinical literature. Dissociation is seen as a way of resolving the dilemma of attachment to

an abusive caregiver (Bacon and Richardson, 2001). Dissociation is thus not solely seen as a defence against trauma, but within the context of insecure attachment leading to the construction of multiple, incompatible models of the self (Bacon and Richardson).

### **Models of PTSD in maltreated children**

A number of models pertaining to PTSD have been formulated, such as psychodynamic, learning models, behavioural and cognitive models, and developmental models (Morrisette, 1999). Many current models incorporate various elements of earlier models, and seek to account for both psychological and biological symptoms. Trauma is a necessary, but insufficient, cause of PTSD, with many other factors modifying the response to trauma (McFarlane & Yehuda, 2000). McFarlane & Yehuda warn that a simplistic view of PTSD may underestimate its complexity and lead to simplistic or incomplete treatment plans.

Those working with maltreated children postulate integrated developmental and contextual models in order to account for the myriad of factors pertaining to the development and maintenance of PTSD in children (Cicchetti and Toth, 1995; Putnam, 1997).

Culbertson (1999) suggests that intervention with maltreated children must take into account both developmental influences (such as children making developmental transitions at varying ages), and contextual influences (such as protective factors, secure/insecure attachments, safety from further maltreatment, culture, socio-economic status, and family variables). Some models (e.g. Foy, Madvig, Pynoos and Camilleri, 1996) also attempt to explain why some children appear more at risk for the development of PTSD than others, accounting for the interaction of protective or resiliency factors.

### **Assessment**

Currently, there is no single “gold standard” for assessment of PTSD in children (AACAP, 1998). Assessment of PTSD requires a multi-modal approach including

direct interviewing of the child, and interviews with family and school (McNally, 1991, 1996). Interviewing of parents should include family history, child's developmental history, parents account of trauma and aftermath, child's treatment history, child's current functioning and any parental reactions to the trauma (AACAP, 1998; Davis and Siegel, 2002).

While there is agreement that the child needs to be directly asked about symptoms as they relate to the stressor, it is believed that parents and teachers underestimate distress in children, and may not be aware of symptoms not easily observable (AACAP, 1998; Scheeringa et al, 2001). As such, structured interviews incorporating direct questioning of symptoms, even with young children, can yield helpful information (Amaya-Jackson, Socolar, Hunter, Runyan, & Colindres, 2000; Davis & Siegel, 2002; Yule and Canterbury, 1994). While a variety of self-report measures are available for children over the age of 8 years (Nader, 1997; Perrin et al, 2000), little effort has been directed at developing standardised measures suitable for children less than 8 years of age (Perrin et al, 2000).

## ***Summary***

In summary, maltreated children are at considerable risk for the development of PTSD or post-traumatic stress symptoms, alongside numerous other co-morbid disorders and long-term effects. Current DSM-IV diagnostic criteria may fail to adequately capture the post-traumatic profile of abused and neglected children, and future research may continue to address such limitations.

At present, assessment of maltreated children requires a multi-modal, multidisciplinary approach in order to adequately assess for the possibility of PTSD, whether as a distinct diagnostic entity or a cluster of symptoms experienced by the child and impacting on their functioning and wellbeing. Given the concerns regarding the adequacy of DSM-IV criteria in assessing for PTSD in maltreated children, assessment should incorporate consideration of DSM-IV symptoms, but not be limited to these. A broad screen assessment of children's functioning is likely to provide a clearer picture of the impact of the trauma suffered and better inform intervention and practice.



## **Chapter Three: Treatment**

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### ***Overview***

The following chapter offers an overview of play therapy: it's history, definition, goals, models, and key treatment components. Particular emphasis is then given to considerations of play therapy for maltreated children, the role of post-traumatic play and trauma processing. Following this, current research in the field of treatment for maltreated children is discussed. Consideration is then given to factors determining treatment, such as predictors of outcome, brief therapy, and manualised programs. Finally, practice parameters and guidelines in the treatment of maltreated children are discussed as these relate to key treatment components and the development of the play therapy manual utilised in the present study.

### ***Play Therapy***

#### **History and Definition**

While play has always existed, the use of play in psychotherapy comes from two therapeutic traditions – the psychoanalytic tradition, and the non-directive client-centered tradition (Russ, 1995). Today play therapy remains a major intervention approach with children. Play therapy involves meeting with a child on a regular basis, the development of a trusting relationship, communication through play, and the understanding that the therapist is there to help the child with feelings, thoughts and behaviours (Russ).

The Association for Play Therapy (2001, as cited in Ray et al, 2001, p 89) defines play therapy as “the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development.” In this study, play and activities are the medium in which to access, address and resolve the traumatic experiences of maltreatment.

Play therapy involves a range of media including art, clay, doll-play, puppets, storytelling, board games, and the use of toys, blocks, activities, family play (e.g.

Carlson & Arthur, 1989; Crisci, Lay & Lowenstein, 1998; Gil, 1991; James, 1989; Lowenstein, 1999; Oaklander, 1988; Veltman & Browne, 2002). The use of sandplay is also common (e.g. Labovitz-Boik & Goodwin, 2000; Mitchell & Friedman, 1994; Pearson & Nolan, 1995; Pearson & Wilson, 2001).

### **Goals of Play Therapy**

Play is recognised as an integral part of a child's life. In a child's development, play is the way in which children understand, learn, make sense of, and interact with their environment, allowing integration of troublesome feelings (Ablon, 1996; Cattanach, 1992; Landreth, 2001).

There are three main goals of play therapy: (1) through a healthy attachment with the therapist, children are encouraged to increase feelings of self-worth and self-acceptance, (2) children are encouraged to use play as a way to express, explore and work through their interpersonal conflicts and issues, and (3) children are encouraged to understand the purpose of their play, its association with past events, and its connection to feelings and behaviours (White & Allers, 1994).

Play therapy aims to relieve emotional distress through a variety of imaginative and expressive play materials (Webb, 1991). Through play, children work off past emotions and find imaginary relief for past frustrations, integrate various lines of development, practice logical thinking and verbal expression, dissipate and gain symbolic mastery over anxiety producing situations, interpret and organise reality, and anticipate expected experiences in the future (Varkas, 1998).

Play also enables children to expose themselves to the trauma *in vivo* and to restructure their experiences at bodily, affective and cognitive levels of functioning (VanFleet et al, 1999). Play therapy offers a useful treatment approach for pre-verbal children who have experienced trauma (Gaensbauer, 2000), as young children often rely on non-verbal methods of communication and participate more fully through play, drawing or acting (Cohen, Berliner & March 2000).



## **Models of play therapy**

Play therapy may be either directive/structured or non-directed/unstructured. In directive approaches, the therapist directs the activity to facilitate discussion. In non-directive approaches the child selects and uses the play items as they choose. Non-directive approaches are often open-ended and paced according to the needs and symptoms of the child. However, many therapists use a combination of the two approaches. Schaefer (2001) describes 'prescriptive' play therapy, whereby the clinician combines a variety of play interventions into a specific treatment program for a particular client. Such prescriptive therapy includes evidence based practice, treatment specificity, and the following of practice guidelines.

### *Non-directive approaches*

Non-directive play principles emphasise the child's innate ability to direct their own healing through the medium of play when provided with a safe environment and a therapist who allows and accepts all the child's thoughts and feelings (Landreth, 2001). Non-directive play therapy uses play rather than verbalisation as the principal means of communication (Wilson & Ryan, 1994).

A trusting relationship allows children to express feelings through actions, language and play. The therapist's role is to listen, understand, and respond to the child, and facilitate the awareness of confused or conflicting feelings. Non-directive play therapy is non-coercive and the child sets the pace for change, something of particular importance for children who have been sexually abused (e.g. Gil, 1991; Johnson, 1989; Ryan & Needham, 2001; Varkas, 1998)

### *Directive approaches*

In the literature regarding PTSD in children, most advocated treatments tend to be directive. Based on clinical evidence, theoretical grounds, and general treatment methods for traumatised children, it is assumed that "the cycle of re-traumatising play must be broken by active intervention from a therapist who directs the trauma play so as to create a sense of mastery" (Schaeffer, 1994 p 305).

Directive approaches provide some guidance for the child in working through the trauma, and offer assistance when the child becomes stuck or risks re-traumatisation through their play. Intervention is paced to the needs of the child in order to address issues yet remain safe. Focus is on relieving symptoms and helping the child integrate the traumatic experience. This occurs through active structuring of the child's play in order to understand the child's experience of the trauma, and the impact it has had on development (Gaensbauer, 2000).

### **Developmental considerations**

Play is part of the normal cognitive and emotional development of children. Play may be parallel (children playing alongside one another) or constructive (children working together). Play follows a series of developmental stages; from concrete to symbolic to dynamic (or imaginative). Consideration needs to be given to Piaget's stages of development; sensorimotor (0-2 years), preoperational (2-7 years), concrete operational (7-11 years) and formal operational (11-15 years) (Phillips, 1981).

As such, play behaviour needs to be assessed and addressed in relation to these developmental stages. Children who demonstrate regressed behaviour may be able to be progressed through the developmental stages by focusing on moving them through the phases with appropriate play material. For example, allowing a 7-8 year old child who demonstrates a fascination with sensory play, time to fully experience, appreciate and move forward.

### **Play in maltreated children**

The play behaviours of abused and neglected children have been studied from researchers of various theoretical orientations. In a review of the literature, White and Allers (1994) identified a number of characteristics of play behaviour in maltreated children including: developmental immaturity (the loss of recently acquired developmental skills or a failure to learn developmentally appropriate behaviours), opposition and aggression, withdrawal and passivity, self-deprecating

and self-destructive behaviour, hypervigilance, sexual behaviour, and dissociation. Many of these behaviours are reflective of PTSD symptomatology.

The two predominant play patterns found in abused children are (a) unimaginative and literal play and (b) repetitive and compulsive play (White & Allers, 1994; White, Draper & Jones, 2001). Maltreated children may demonstrate communication and symbolic play difficulties. Ryan (1999) suggests that children who lack the capacity to play imaginatively require the therapist's help to extend this ability in order for play therapy to be most effective.

An investigation of the differences in social skills and play behaviour between maltreated and non-maltreated 3-5 year old children, revealed maltreated children had significantly poorer skill in initiating play with friends, maintaining control, and a greater number of problem behaviours (Darwish, Esquivel, Houtz, & Alfonso, 2001). However, no differences were found in regard to social participation, or the cognitive level of play. Darwish et al concluded that maltreatment has a negative impact on children's developing interpersonal skills.

Holmberg, Benedict, and Hynan (1998), found that gender, trauma histories (exposure to violence or attachment disturbance), and the interaction of these, impacted on the frequency and types of themes of children in play therapy. Children tended to play out issues related to their emotional concerns, and the types of stressors to which they had been exposed. Boy's play themes evidenced more aggression, girls more nurturing, fixing, and controlling.

Ryan (1999) examined play behaviours in maltreated and neglected children, suggesting non-directive play therapy as a suitable intervention in maltreated children, particularly where legal or evidential requirements prohibit the use of more structured intervention. Ryan highlighted the importance of patterns of attachment, and the developmental impact of maltreatment on both emotional and cognitive capacities when treating maltreated children. For example, maltreated children often require clear limits or boundaries in the playroom, age appropriate knowledge of the therapist's role, stable and predictable intervention, and acceptance of emotional responses.

In working with sexually traumatised children Kelly, (1995) suggests that play therapy may involve a series of cycles, in which the child returns to three core process: testing the therapeutic relationship, addressing trauma, and undoing denial. Kelly suggests, that where trauma histories are extreme, progress in therapy is better understood as cyclical, rather than as progressing through stages.

### *The role of post-traumatic play*

Play therapy with traumatised children often focuses on post-traumatic or repetitive play. The phenomenon of posttraumatic play is addressed both as a symptom of trauma, and a means for healing (Varkas, 1998). By the re-enactment of the trauma through play, the strength of the trauma diminishes, and the child learns to actively control their feelings about the trauma, and to gain a sense of mastery (Cattanach, 1992; Gil, 1991; Webb, 1991). Thus, while the extent to which children are able to help themselves through play is not fully known, it appears that children who develop PTSD need additional help in processing their memories, in order to overcome the traumatic experience and advance through developmental stages and transitions.

## **Sand-play**

### *Definition*

Sand-play comprises the use of miniatures within a confined space (sand-box) in order to tell a story, or make a “world”. Basic necessities of sand-play include two waterproof sandboxes (one wet, one dry, 23” by 28” by 4”), the bottom of which is painted blue. A jug of water should also be available for use. A selection of miniature objects arranged on open shelving where they can be easily viewed is also necessary. Categories of miniature objects include people, animals, plant life, environments, transportation, and miscellaneous items such as medical, containers, food, and symbols (Labovitz-Boik & Goodman, 2000; Mitchell & Friedman, 1994).

### *Therapeutic benefits of sand-play*

Sand and water are powerful tools in fantasy play, allowing for creative expression (Labovitz-Boik & Goodman, 2000). Sand-play enables the client to create a world

regarding inner thoughts and feelings. This world can be viewed, touched, experienced, changed, discussed and photographed. An emotional experience that may not be understood or resolved cognitively may be given visible shape. The symbols and objects used in the sand-play serve as a common language. This is helpful for children who are unable to express their feelings. Sand-play can be used across ages, languages, cultures, and developmental levels (Labovitz-Boik & Goodman, 2000).

### *The role of the therapist*

In sand-play the role of the therapist is to facilitate the healing process for the client by helping to contain the safety of the therapeutic space, to link the client with the sand-play and support the process, being a co-explorer on the journey of self-discovery, and acting as a witness and mirror to what is occurring in the tray (Labovitz-Boik & Goodman, 2000).

### *Sand-play with children*

While play is a natural form of expression for children, language and abstract thinking are limited in young children. As such, there is less narrative processing of a tray, and children do not often have conscious knowledge of what is happening inside them during play, and may not choose to talk about their experience. Sand-play with children is often more active, and the therapist sometimes needs to enforce rules and limits with children in order to contain the play (Labovitz-Boik & Goodman, 2000).

Studies across age groups have demonstrated developmental aspects to sand-play comprising three stages: animals and vegetation (up to 6 years); battles and conflicts (7-11 years) and real life scenes with integration of community (11 to adult (Labovitz-Boik & Goodman, 2000). Stewart (1988, as cited in Labovitz-Boik & Goodman, 2000) also outlined a number of stages observed in sand-play with children. In the first stage (infancy – 2 years) there is focus on hiding and finding, burying and uncovering, and filling trays with an abundance of objects. In the second stage (1/2-3/4 years) the theme becomes chaos, creating and destroying. In the third stage (3/4-6/7 years) there are more organised battles with central figures in conflicts, and the development of testing the limits. In the fourth stage (6/7 to

11/12 years) dualities become displayed, battles become more complex, differences between male and female trays emerge, there is the appearance of fences and boundaries, and connection between previously separate areas.

While it is not common to engage in sand-play with children under 2 years of age, knowledge of the developmental progression of trays serves to inform the clinician of the possibility of regressive behaviour (Labovitz-Boik & Goodman, 2000).

### *Sand-play with maltreated children*

Sand-play has been used by a number of clinicians in addressing maltreatment and trauma. Sand-play may be used in directive trauma processing by asking the child to make a scene about a particular trauma or elements of the trauma, and to express their thoughts and feelings about the trauma (Labovitz-Boik & Goodman, 2000).

Both Grubbs (1994), and Carey (1990) describe the use of sand-play in abused children's healing through the process of consecutive trays. Through sand-play these children were able to uncover feelings, and talk about problems or frustrations. At the completion of therapy both had a reduction in presenting symptoms, and significant inner healing through insight and understanding of their inner worlds. Parson, (1997) describes treatment with children exposed to violence in the community, using *in vivo* systematic desensitisation and hierarchy. Through the use of sand-play, children were able play out situations that resemble the original traumatic situation, allowing the child to address the trauma through hierarchal steps.

## ***Current Research***

### **Child psychotherapy research**

The last two decades have witnessed an increasing focus on child psychotherapy research, with effect sizes of .7-.8 demonstrated (Kazdin, 1994). Therapy with children appears to be better than no treatment, with treated children being 76-79%



better off than those not treated (Casey and Berman, 1985; Kazdin, 1994; Weisz, Weiss, Alicke and Klotz, 1987; Weisz, Weiss, Han, Granger and Morton, 1995).

Therapy has been shown to be more effective for children than adolescents; paraprofessionals more effective with younger children; professionals equally effective across ages; behavioural treatments more effective than non-behavioural; and treatment focused on targeted problems has shown the strongest effect (Weisz et al, 1987; Weisz et al, 1995).

However, many studies involve research-based as opposed to clinic-based referrals, raising questions regarding the generalisation of results (Weisz and Weiss, 1989). Weisz and Weiss conclude that the effectiveness of clinic-based psychotherapy is not as strong as meta-analyses indicate, and that replication with controlled conditions of therapy, specific and clearly delineated treatment targets, and therapist training is necessary in clinics. Further, treatment research often focuses on the impact of treatment techniques rather than other contextual influences, (such as parent, child, family, therapist), that may moderate outcome (Kazdin, Bass, Ayers & Rodgers, 1990).

### **Treatment of PTSD**

A survey of treatment practices in treating childhood PTSD revealed that a wide variety of modalities were in use (Cohen, Berliner & March, 2000; Cohen, Mannarino and Rogal, 2001), with CBT, family, and nondirective play therapy being the preferred modalities (Cohen, Mannarino and Rogal, 2001).

In the treatment of children and adolescents with PTSD, empirical evidence favours CBT, education regarding PTSD, and the inclusion of parents, with most CBT interventions including exposure, cognitive restructuring, anxiety reduction and psycho-educational components (Perrin et al, 2000). Treatment tends to focus on PTSD symptomatology, with the CBT format being based on the nature of the trauma (Foa, Keane & Friedman, 2000).



The majority of outcome studies in the area of PTSD in maltreated children have focused on CBT for sexually abused children (Cohen, Mannarino, Berliner & Deblinger, 2000; Deblinger, Lipman & Steer, 1996; Lanktree & Briere, 1995). Of these studies, trauma focused CBT has been found to result in greater reduction in PTSD symptomatology and sexualised behaviour than non-directive supportive therapy (NST) in sexually abused preschoolers (Cohen & Mannarino, 1993, 1996a, 1996b, 1998a, 1998b) with treatment gains being maintained at one-year follow-up (Cohen & Mannarino, 1997). The involvement of parents in treatment has been a significant factor in successful treatment outcome (Cohen & Mannarino, 2000b; Deblinger et al, 1996; King et al, 2000).

Although there are more rigorous studies of child sexual abuse than child physical abuse, there is general support of abuse-specific treatment, with models emphasising the role of CBT and skill teaching to parents (Kolko, 2000). Treatment studies for child physical abuse have generally reported reductions in negative parental and child behaviour, with mixed evidence to suggest improvements in internalising symptoms (Kolko, 2000). A recent literature review identified therapeutic day-care as the most common intervention for physically abused children. However, while there was some improvement in symptoms, there was little follow-up to ascertain if improvements were maintained over time (Oates & Bross, 1995).

While CBT treatments are considered the first line approach, it is unclear from existing research, which components are the “active ingredients”, if different CBT components are more effective for certain symptom patterns or developmental stages (Cohen, Berliner & March, 2000) or how interventions need to be adapted to account for different developmental levels in children (Yule & Canterbury, 1994). Studies have also been largely limited to sexual abuse, with relatively few studies of other forms of maltreatment. Further, CBT treatments appear more amenable to research studies, with many other forms of treatment currently utilised by clinicians not empirically validated.

However, based on this research, key implications for practice can be determined. These include the incorporation of some CBT components when treating children

with trauma related symptoms, assessment and treatment of general emotional and behavioural problems co-morbid with PTSD, the inclusion of parents in treatment, and inclusion of the impact of other forms of maltreatment such as domestic violence and physical abuse (Cohen et al, 2000).

### **Play therapy research**

While play therapy has widespread acceptance as a treatment modality for abused, developmentally delayed or behaviourally maladapted children, there exist few well-defined and well-executed studies of play therapy's effectiveness (Cohen, Berliner, & March, 2000). Phillips, (1985) in a review of play therapy research commented that despite little outcome research the use of play therapy has increased. Currently much research relies on the presentation of case studies and anecdotal reports, with difficulties including limited measures, small sample size, application to varied populations, and lack of generalisation (Leblanc & Ritchie, 1999, 2001).

Recent meta-analyses of play therapy have revealed effect sizes of .66 (LeBlanc & Ritchie, 2001), and .73 (Ray, Bratton, Rhine, & Jones, 2001). Ray et al commented that their results were stronger than those of previous meta-analytic studies, perhaps due to the increasing number of studies available to include in meta-analyses. Two key factors in increasing the effectiveness of therapy appear to be parental involvement and the number of treatment sessions, with effectiveness peaking at around 30-35 sessions (LeBlanc & Ritchie, 2001; Ray et al, 2001). Further, Ray et al (2001) commented that studies that distinctly defined play therapy procedures offered more successful play therapy outcomes.

Play therapy with maltreated children has tended to focus on relieving symptoms and helping the child integrate the traumatic experience. This can occur through active structuring of the child's play in order to understand the child's experience of the trauma, and the impact it has had on development (e.g. Gaensbauer, 2000), or through re-enactment of the trauma whereby the child is able to "show what

happened” through the use of clay, miniature or art, and thus the child gains insight into what happened to them (e.g. VanFleet, Lilly & Kaduson, 1999).

Many interventions incorporate elements of both play therapy and CBT. Nurcombe, Wooding, Marrington, Bickman and Roberts (2000), in a review pertaining to treatment in child sexual abuse determined successful treatments involved group, combined individual and group play therapy, and CBT. Copping, Warling, Benner, and Woodside (2001) outline a child treatment pilot study for maltreated children aged 3-17 consisting of a treatment intervention rooted in theories of trauma, attachment, parent training and CBT. Initial results indicate the program to be effective with significant reductions in conduct disorder, problems in social relations, and caregiver depression. Improvements were also noted in children’s post treatment scores of oppositional behaviour and separation anxiety.

Knell (2000) describes cognitive behavioural play therapy (CBPT) specifically designed for pre-school and school aged children. Knell contends that with minor modifications CBT can be used with young children. In CBPT modelling and role-playing occur via puppets or dolls in problem solving particular problems the child has. A variety of treatment techniques including bibliotherapy, drawings, clay, and puppet/doll play were used. For CBPT to be effective it must provide structured, goal directed activities as well as allow time for the child to bring spontaneous material to session (Knell, 2000). Knell suggests that the length of treatment time might be increased and flexibility maintained for children who have suffered multiple trauma. Knell describes the case study of a 5-year old sexually abused girl. Pre and post measures using the Child Behaviour Checklist showed reductions in withdrawn behaviour, somatic complaints, social problems, and thought problems, with treatment gains maintained at 8 months follow-up.

Bonner, Walker, and Berliner (2002), describe the comparative study of two group treatment approaches for sexually abused children, one based on cognitive behavioural therapy principles, the other on dynamic play therapy. Caregivers were involved in both treatment approaches, and treatment consisted of 12 one-hour group sessions. Both approaches were found to be equally effective in reducing sexualised behaviour.

## **Limitations of play therapy research**

While results from meta-analyses appear promising, much research is needed to provide a firm empirical base regarding play therapy. In particular, there is a need to compare play therapy with other techniques (Ray et al, 2001), investigate the types of presenting problems for which play therapy is more effective (LeBlanc & Ritchie, 2001; Ray et al, 2001), define the processes and characteristics leading to effective therapy, and identify the long-term benefits of play therapy (LeBlanc & Ritchie, 2001).

Studies pertaining to play therapy with traumatised children have revealed inconsistent definitions of play therapy, inadequate definitions of the qualifications and role of the play therapist, non-standardization of play therapy materials and modalities, and inadequate or flawed statistical design (LeBlanc & Ritchie, 2001; Phillips, 1985; White & Allers, 1994).

Impediments to play therapy research noted by Phillips (1985) included; a discrepancy between empirical understanding and clinical practice, the need for well-controlled studies, a lack of convincing findings, and lack of a conceptual model as to how play therapy works. Phillips commented that play therapy with CBT components, such as reinforcement, rehearsal, modelling, suggestion and systematic desensitisation, showing the greatest promise. Phillips surmised that the specificity of treatment goals and focused methods of CBT partially account for such success, and that play therapy needed to be investigated with the same precision.

Future directions of play psychotherapy research outlined by Russ (1995), included: process research on play and cognitive/affective processes, specific play interventions with specific populations, refining of play techniques, and research with play intervention modules. Russ suggested the development of 6 – 12 week play module programmes with different foci, for example, a trauma focussed approach. Further, Russ suggested that bridging the gap between research and practice was necessary and could be implemented by building in assessment and evaluation of the play process in therapy; linking play to treatment goals at the

outset of therapy; and remaining focussed and active by targeting specific problems in a focused way.

The combination of numerous limitations such as the lack of empirical evidence and the frequent use of play therapy in clinical settings indicates the need for further research in order to justify the ongoing use of play therapy as an intervention (Kazdin, 1994; White & Allers, 1994). Ruggerio, Morris and Scotti (2001), suggest that data-guided case reports of other treatment modalities are an important first step in identifying effective treatment techniques, alongside documentation of complications and developmental considerations that can then inform treatment planning.

In summary, much is still to be learned about play therapy, both in terms of process and outcome. Play therapy is a generic label and covers a variety of theories and interventions requiring elucidation. Indeed, “what play therapy needs is a systematic programme of research that clearly sets out its hypotheses, designs well-controlled studies, carefully selects its subjects, measures meaningful outcomes, and uses appropriate and informative statistics” (Phillips, 1985, p 758). Play therapy and children stand to gain much by the provision of a stronger empirical foundation.

### **Further treatment considerations**

#### *Predictors of outcome in therapy*

In examining factors that mediate treatment outcome in sexually abused preschool children, Cohen and Mannarino (1996c) found a strong correlation between parental emotional distress and treatment outcome independent of the type of treatment provided. This indicates the importance of addressing parental distress in treatment. Investigation as to the impact of child and family characteristics on treatment outcome of sexually abused children revealed mediating factors included children’s abuse related attributions and perceptions, family cohesion and adaptability, parental support of the child, and parental emotional reaction to the child’s abuse (Cohen & Mannarino, 1998b; 2000).

In a recent study examining reasons for drop-out in play therapy, Campbell, Baker and Bratton (2000) found drop-out more likely to occur in single parent families who were young and economically disadvantaged. In order to improve retention Campbell et al suggested making services more accessible to families by considering proximity, access to transportation, and the maintenance of scheduling flexibility.

### *Brief Therapy*

Brief therapy is defined as 12 sessions or less with a focus on providing cost-effective, goal oriented treatment (Johnson, 2001). While there is no empirical evidence regarding optimum length of treatment, most CBT programs for paediatric mental disorders are between 8-16 sessions (Foa et al, 2000). Cohen, Berliner & March (2000) comment that clinically, most children and adolescents with uncomplicated PTSD make substantial improvement with 12-20 sessions of PTSD specific psychotherapy. Children who have experienced prolonged victimisation, poor premorbid adjustment, co-morbid conditions, or who have chronic PTSD with dissociative symptoms may require much longer interventions (Foa et al, 2000). As PTSD may be a waxing and waning condition, treatment may be pulsed according to developmental need such as transitions, changes in living situation or further traumatic exposure (Cohen, Berliner & March, 2000; James, 1989).

A number of short term play therapy interventions for children have been documented. Shelby (2000) states that short-term therapy is the rule in clinical practice rather than the exception, with most therapy ranging from 3-5 sessions. Shelby suggests that due to a different perspective of time, brief therapy is more in keeping with a child's understanding. As such therapists need to identify 'therapeutic windows' in the child's development, and to work within these timeframes.

Short-term therapy for abused and neglected children has demonstrated some effectiveness. For example, a sexually abused boy was able to use the doll's-house to facilitate disclosure in four sessions (Klem, 1992, as cited in Johnson, 2001);



and a 10 year-old boy used sand play to address trauma at home in 10 sessions, with significant reductions in aggressive and impulsive behaviour, and improved social skills (Allan & Berry, 1987, as cited in Johnson, 2001).

Kot (1995, as cited in Johnson, 2001) conducted an intensive short-term play therapy intervention for children who had witnessed domestic violence. Children were randomly assigned to either a treatment group or a control group. Treatment consisted of twelve 45-minute play therapy sessions over a period of two weeks. Children in the experimental group displayed an increase in self-concept and in play behaviours, with reductions in externalising problems and total behaviour problems on the Child Behaviour Checklist.

In a comparative analysis of brief, intensive, individual play therapy and sibling group play therapy for children who had witnessed domestic violence Tyndall-Lind, Landreth & Giordano (1999) found both modalities to be equally effective. Children who received treatment displayed an increase in self-concept, a decrease in overall behaviour problems, a decrease in both internalising and externalising problems, and decreases in aggression, anxiety and depression, when compared to a control group.

In comparison, Reams and Friedrich (1994) examined the efficacy of time limited play therapy with maltreated preschoolers. Treatment consisted of 15 weekly sessions of 50 minutes duration, the use of a therapy manual and observations of play. Of the 13 outcome measures used there was change in the treatment group in isolated play only, and no significant difference between the two groups at 10-week follow-up. Reams and Friedrich surmised the use of graduate students with minimal experience in play therapy and insufficient treatment time as possible reasons for these results.

### *Manualised Programs*

A recent advance in research has been the use of therapy manuals in treatment. Manuals serve to specify and guide the therapist through treatment and allow for better assessment of treatment integrity and replication (Kazdin, 1994). In the last



decade a number of treatment approaches for work with sexually abused children have appeared in the literature. While some treatment manuals exist, most are designed for latency aged children and adolescents, with few specific treatment programmes for use with preschool or young children (Cohen & Mannarino, 1993). Examination of the play therapy literature indicates that some play therapy manuals exist. However, these appear to be limited to post-graduate research, and are not easily accessible or readily available for use in clinical practice. Further, there is little available for maltreated children in general, particularly those of younger age.

### ***Treatment for maltreated children***

Maltreated children present with complex treatment needs, with recommendations for a comprehensive, multi-component approach to treatment (Shirk and Eltz, 1998). Interventions with multiply abused children need to consider both developmental issues and attachment to form a framework for understanding the disturbed parent-child relationship (Culbertson and Willis, 1998; Friedrich, 1996).

Outcome studies for maltreated children have tended to focus on one form of abuse, with little information regarding the effectiveness of treatment for children who have experienced multiple forms of abuse (Shirk and Eltz, 1998). Treatment needs to address issues of safety, stabilise problematic behaviours, provide positive experiences, compensate for developmental deficits, and process traumatic memories (Streeck-Fisher & van der Kolk, 2000), with possible needs for staging therapy for repetitively traumatised children (Gallagher, Leavitt & Kimmel, 1995). Treatment studies for maltreated children suggest that no single treatment approach will be applicable to all children, as maltreated children present with diverse emotional and behavioural difficulties (Cohen, Berliner & Mannarino, 2000).

The International Society for Traumatic Stress Studies (ISTSS) published practice parameters and guidelines for the treatment of Post Traumatic Stress Disorder (PTSD) in children and adolescents in order to inform 'best practice.' The ISTSS suggest that well-controlled studies consist of clearly defined target symptoms; reliable and valid measures; the use of blind evaluators; assessor training;

manualised, replicable, specific treatment programs; unbiased assignment to treatment; and treatment adherence (Foa et al, 2000). In addition, efficacious treatments require the use of clinical samples, multi-method assessment, the assessment of the clinical and functional significance of outcomes as well as symptom reduction, and the assessment of long-term outcomes (Chambless and Hollon, 1998; Kazdin and Weisz, 1998).

The American Academy of Child and Adolescent Psychiatry (AACAP; 1998) Official Action regarding practice parameters for the assessment and treatment of children and adolescents with PTSD suggest that despite the paucity of empirical treatment outcome studies clinical consensus suggests the essential components of treatment for children with PTSD include (a) direction exploration of the trauma, (b) exploration and correction of inaccurate attributions regarding the trauma and (c) inclusion of parents in treatment.

## ***Summary***

In summary, psychotherapy appears to be an effective treatment with children, with recent meta-analyses indicating that play therapy may be as effective as other forms of therapeutic intervention. Key components for inclusion in treatment are trauma focussed therapy and the inclusion of parents. Play therapy offers a developmentally appropriate format, particularly if it incorporates CBT components and offers trauma specific intervention.

The incorporation of key treatment components as outlined in the research literature and practice parameters are pivotal in the development of manuals designed to address the needs of children traumatised by maltreatment. Such manuals also need to extend the maltreatment literature by examining the effectiveness of trauma-focussed treatment for children who have witnessed violence, and experienced physical abuse or neglect. As Foa et al (2000, p 540) suggest that the “creative integration of new approaches that have been found helpful in other conditions and that have a theoretically sound foundation are encouraged in an effort to optimise treatment outcome.” The following chapter outlines the development of a play therapy manual that seeks to integrate the most

salient treatment factors in order to provide a comprehensive yet flexible and broad-spectrum intervention for maltreated children.

## **Chapter Four: Development of treatment manual**

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### ***Overview***

This chapter describes the development of a play therapy manual for the treatment of children traumatised by maltreatment. The research literature and clinical practice outlined in earlier chapters informs and guides the rationale for the present study. Stemming from this, key components of treatment are discussed, and an overview of the treatment manual is provided.

### ***Rationale***

The current study is informed by the ‘best practice’ and efficacious treatment guidelines summarised previously. As such the following elements are considered:

- Conceptualisation of PTSD
- Evaluation of a short term play therapy intervention
- Clear definitions of maltreatment
- Operational definitions of play therapy and key treatment components
- An empirical examination via well-controlled individual case studies
- The use of a clinical sample
- Widening of the scope of PTSD literature via the inclusion of children who have suffered physical abuse, multiple abuse or witnessed domestic violence
- Identification of patient characteristics and possible complications
- Multi-method assessment
- Consideration of developmental implications and possible treatment modifications necessary to address different developmental stages
- Treatment focused on both PTSD symptomatology and general emotional/behavioural problems via clearly defined target symptoms
- Key components informed by current research such as trauma focused treatment, education of parents and children regarding PTSD and the inclusion of parent/caregivers
- The use of valid and reliable measures

- Treatment formulation and operational description of procedures via a treatment manual in order to inform treatment adherence, evaluate specific treatment components, and allow for replication
- Analysis of outcome both in terms of symptomatology, functioning and long term follow-up

## ***The Present Study***

The present study aims to incorporate a number of key elements pertinent to the literature regarding PTSD in children. Key components include consideration of the safety of the child, the inclusion of parents or caregivers in treatment, and integrated, trauma-focused treatment. These elements inform the development of the treatment manual.

## **Major Components**

### *Safety of the child*

An essential component in working with traumatised children is the establishment of a safe environment within which the traumatic event can be remembered and discussed (Yule & Canterbury, 1994). This is further demonstrated in children being advised of the purpose of play therapy and the form that sessions will take. Throughout the therapeutic process the child's ongoing safety is monitored, particularly in terms of return of the alleged offender into the child's life, or the impact of court proceedings. At the completion of therapy ongoing safety is addressed with the child via safety education.

### *Inclusion of parents/caregivers*

The inclusion of parents/supportive others in treatment is seen as important for the resolution of PTSD symptoms in children (Cohen & Mannarino, 2000b; Copping, Warling, Benner & Woodside, 2001). Parent/caregiver emotional reaction and support are powerful mediators of a child's PTSD symptoms, and inclusion helps parents to monitor the child's symptomatology, learn behavioural management techniques, and help alleviate their own emotional distress (Cohen & Mannarino, 2000b). The involvement of parents or caregivers in treatment with maltreated

children may also facilitate and strengthen attachment relationships, and facilitate understanding of behavioural difficulties that the child may be experiencing.

### *Integrated Treatment*

The integration of treatment is important to address symptoms and dysfunctions beyond those related to PTSD. Integrated treatment involves the use of CBT techniques as outlined by AACAP (1998) and ISTSS (Foa, Keane & Friedman, 2000) guidelines for best practice, alongside play therapy techniques that acknowledge play as the child's primary form of working through trauma.

CBT elements include the use of homework, identification of feelings, thoughts and behaviours, attributions regarding the trauma, direct processing of the trauma, relaxation and coping skills, and the focus on symptom reduction via weekly behaviour reports. Play therapy elements include the use of identification through stories, expression of self and feelings through art, the use of games, and trauma processing via sand-play. Further sessions consist of both structured, directed activities and non-directive 'free play' time to allow for the child to engage in spontaneous play.

### *Trauma focussed therapy*

Clinicians vary as to the degree to which exposure is advocated, but agree that some form of trauma-focussed discussion is a necessary and critical component (AACAP, 1998). Friedrich (1996) suggests that a trauma-focussed approach that treats the child's specific symptoms is more important than the treatment modality (individual, group, family) used. The trauma-focussed treatment of the present study utilises retelling and reworking the trauma through sandplay.

### ***Treatment Manual***

A 42-page, treatment manual was developed by the author for the purposes of this study (Woolf & Woolley, unpublished manuscript). The manual is based on elements of play therapy used within SSU for the assessment and treatment of maltreated children, and practice guidelines and recommendations in the treatment literature. The manual outlines specific goals for each session, alongside materials

required. Flexible use of the manual is recommended to account for age and developmental factors, with treatment staged such that further sessions can be inserted at various points in order to facilitate treatment goals.

The treatment manual comprises 12 sessions of one-hour duration. Each session is divided into five parts: homework (5 minutes), story-time (5 minutes), activity time (20 minutes), free play (20 minutes) and game time (10 minutes). Times outlined provided a guideline and flexibility was maintained when a child required extra time to finish an activity or to finish their play. Children were informed 5 minutes prior to the end of each session.

In addition to sessions with the children, four separate sessions were held with the parents/caregivers in order to outline stages in treatment and address any concerns that may have arisen.

### **Overview of treatment manual**

An overview of the treatment manual is outlined below.

Session 1: A session to build rapport, orient the child to the therapy process and the reason for therapy, and to learn about the child. Tasks focus on the child's likes, a picture of themselves, and three wishes.

Session 2: Focus of this session is on the child's family. The child draws a picture of their family and talks about the people in their world.

Parent Session: A session with the parents is held to outline what has occurred to date, talk about what happens next in therapy, and provide a forum for any questions or concerns.

Session 3: An introduction to feelings and an assessment of the child's ability to recognise and deal with different feelings.

Session 4: Focus is on each of the four main feelings (happy, sad, mad and scared), and discussing the links between feeling, thinking, and doing.

Session 5: The session concentrates on difficult or troublesome feelings "worry bubbles," and ways of coping with them.



Parent Session: A forum for the therapist and parents/caregivers to discuss progress and concerns.

Session 6: The child is given the opportunity to tell their life story, including times of trauma or difficulty.

Session 7: The child locates the trauma and feelings associated with it through the use of paper dolls.

Parent Session: An opportunity to discuss concerns and also the possible implications of future trauma processing work on the child's behaviour.

Session 8-11: Trauma processing through sand-play or other play methods available such as clay, art or puppets.

Parent session: Feedback regarding the trauma processing work undertaken by the child and discussion regarding ongoing concerns, needs and any changes noted by parents/caregivers. Assessment can be made at this point as to whether therapy needs to continue.

Session 12: A review and summary of what has been learned, and an opportunity for the child to comment on what they found helpful.

Joint Session: A time to acknowledge and celebrate the child's achievements with the presentation of a certificate, bag of goodies reminding them of key aspects of therapy, and going through the workbook with the caregiver.

## ***Summary***

The development of a play therapy manual for the treatment of children traumatised by maltreatment has been informed and guided by research findings, limitations in current research, and practice guidelines. Key components in treating traumatised children appear to be trauma processing, incorporation of CBT elements, and the involvement of caregivers. These three elements, alongside key components of play therapy, have informed the development of the manual in an effort to provide a developmentally appropriate intervention for addressing trauma in young maltreated children.

## **Chapter Five: Method**

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### ***Overview***

The following chapter outlines the participants involved in the research, the procedure utilised in the study, and a summary of assessment and treatment measures used.

### ***Participants***

#### **Recruitment**

Participants were gained as part of the normal referral process to Child, Youth and Family, Specialist Services Unit (SSU). SSU provides assessment and therapy for Child, Youth and Family clients, most of whom have experienced some form of maltreatment. Referrals are made by case social workers, and then cases are placed on waiting lists until allocation to workers during team meetings. The SSU team were aware of the research requirements, and forwarded cases of young children who had been maltreated to the author for assessment as to their potential suitability for the study.

#### **Assessment**

Assessment consisted of two parent/caregiver and child sessions to determine eligibility for the research. The interview with the parents, structured interview with the child, and parent and teacher report measures were all administered at pre-treatment and formed the basis of a multi-axial, multi-modal assessment of the child. Assessments were conducted by a trained independent assessor, (a registered psychologist), or the author herself. While ideally the independent assessor would have carried out all assessments, clinical consultation after the first two assessments indicated that this was proving difficult for the children given their age, emotional status, and backgrounds. As such, clinical judgement overrode research requirements in order to provide as little change for these children as possible. If children met criteria and ongoing care and protection matters were assured, consent to take part in the research was obtained from parents/caregivers

and children. Where changes in care-giving arrangements occurred in the process of therapy, consent was also gained from the caretaker/parent as necessary.

### **Ethical Considerations**

The research was conducted in accordance with the ethical guidelines of the New Zealand Psychological Society (1985). The study was reviewed and approved by both the Massey University Human Ethics Committee, and the Research Access Committee (RAC) of the Ministry of Social Development. Participants, parents/caregivers and their social workers were provided with information sheets outlining the research, and what would be expected if they took part. Participants were informed, both verbally and in writing, that participation was voluntary and that the children would still receive therapy if they declined to take part.

Participants were informed as to the goals of treatment in child appropriate language, with parents/caregivers being informed more fully of the reasons for trauma processing. Written informed consent was gained from parents/caregivers and from children. Although signed consent is not necessary in children under the age of 8 years, assent, in a form the child is able to comprehend, is recommended (Parsonson, 1997). In the present study an age appropriate format of written information and consent was utilised in order to ensure the child's understanding of the therapy process and willingness to participate in both the therapy and the research. Examples of information sheets and consent forms are provided in Appendices C-F.

Particular attention was given to providing children with a sense of control over the process both in the provision of their consent, and in providing choices throughout the therapy. Children were made aware that they didn't need to do anything they didn't want to, or if things were too hard for them. Children and parents/caregivers were encouraged to ask questions at any time throughout the therapy process.

Confidentiality was maintained for all participants. Research and clinical data were kept in separate files in a locked cabinet. Audiotapes were coded and kept in a separate secure place. Only the researcher and the clinical supervisor had access to

the research data, although case material and therapy summaries were kept on the child's individual file in order to facilitate care and protections matters. Upon completion of the study, audiotapes were destroyed.

Given the nature of the research, children's safety remained a paramount issue. While the treatment was similar to that which would occur within the unit when working with maltreated children, regular weekly case supervision ensured that therapy could be adjusted or discontinued if required.

Two Maori children participated in the research. In order to ensure that therapy was undertaken and maintained in a culturally sensitive manner, case consultation was conducted regularly within SSU, with cultural supervisors advice and recommendations being followed as necessary.

### **Summary of participants**

Four children who had experienced maltreatment and their parents/caregivers participated in the study. Symptoms and diagnoses are presented in Table 5.1 in the results section. All participants resided with caregivers at the onset of assessment. However, changes in care occurred for some of the participants during the course of therapy. These are outlined more fully in the summaries provided. In order to ensure client confidentiality and safety, fictitious names have been given to the children.

#### *Participant 1*

Brenda, a 7 year-old girl of Turkish and NZ European descent, was referred for assessment due to a history of chronic neglect, parental domestic violence, and the witnessing of her mother's attempted suicide. Brenda and her six siblings were removed from the care of their mother and placed in foster placements. Brenda remained in care with her two younger siblings. Midway through treatment Brenda and her siblings were placed in the care of their father. Brenda's father was involved in the treatment process from that time forward.

Brenda acknowledged her mother cutting her wrists as a scary thing that had happened to her, but did not meet diagnostic criteria for PTSD. Based on the Children's PTSD Inventory, symptoms targeted for change in the weekly behaviour report were a) having bad dreams about what happened, b) trying not to think about what happened, c) being on the lookout, and d) getting upset when reminded about what happened.

#### *Participant 2*

Sam, an 8 year-old boy of NZ European and Dutch descent, was referred for assessment and therapy due to chronic neglect, the witnessing of domestic violence, and alleged physical abuse. Sam and his four siblings were removed from the care of their parents and placed in foster care. Sam and his siblings had been in care for 18 months prior to the referral for therapy. Sam acknowledged a scary thing that had happened to him as being taken away from his parents. He did not acknowledge the physical abuse that had occurred, or any symptoms of trauma, and did not meet diagnostic criteria for PTSD. However, parent and teacher reports indicated significant behavioural concern.

As the physical abuse had been documented, weekly behaviour reports directly addressed the possible impact this might be having on Sam in conjunction with symptoms reported by caregivers and the school. Symptoms targeted were a) having bad dreams, b) thinking about what happened, c) feeling angry and getting into fights, and d) being on the lookout.

#### *Participant 3*

Taylor, a 6 ½ year-old boy of Maori descent was referred for assessment and therapy due to chronic neglect and severe physical abuse. Taylor was placed with caregivers and had been in their care for 1 year prior to assessment and therapy. Taylor's caregivers gained custody of Taylor during the course of treatment, and were involved throughout the therapy process. Taylor identified 'getting bashed up by Ben' as the scary thing that had happened to him. Taylor met criteria for chronic PTSD.

Symptoms targeted for treatment included in the weekly report included a) having bad dreams, b) trying not to think about what happened, c) getting angry, yelling and getting into fights, and d) being jumpy and feeling frightened.

#### *Participant 4*

Tanya, a 7 year-old girl of NZ/Cook Island Maori descent was referred for assessment and therapy due to chronic neglect and alleged physical abuse. Tanya and her four younger siblings were removed from their mother's care and placed with caregivers. Tanya had been in foster care for 8 months prior to assessment and therapy. Tanya identified her mother hitting her as a scary thing that had happened to her, and although Tanya identified symptoms in all three categories (re-experiencing, avoidance/numbing and increased arousal), significant distress was not indicated thus a diagnosis of PTSD could not be made. During the course of assessment and therapy, Tanya had a change of caregiver and also increased access to her father with a view to returning to his care.

Symptoms targeted for treatment in the weekly behaviour report were a) having upsetting thoughts about the hitting, b) trying not to think about what happened, c) finding it hard to go to sleep, and d) loud noises making me jump.

### ***Procedure***

#### **Design**

A case study design was employed, in order to facilitate the examination of the initial treatment manual in order to provide a pilot for further research. The case study design offers advantages at the initial stage of research in that it allows one to closely track changes observed or recorded as the outcome of one client's progress in therapy. Further, the case study may provide a way for research to be brought more fully to bear on clinical practice. This study provides both descriptive analysis of treatment factors and contextual issues, alongside pre and post measures of behaviours or symptoms.

## **Treatment**

### *Setting*

Assessment and treatment took place at Specialist Services Unit (SSU), Grey Lynn Auckland. Sessions occurred in one of two playrooms. Playrooms are equipped with an array of toys, art material, sandpits, books, and games. Sand-play sessions occurred in a purpose built room equipped with a choice of wet or dry sand, and a number of miniature items stored in cupboards. Parent sessions were either conducted at SSU, or at the parents/caregivers homes, dependent on the requests of the parents/caregivers.

### *Therapist*

Therapy was provided by the author, who is currently training as a clinical psychologist and has experience in working with maltreated children both through social work practice and as an assistant psychologist within SSU.

### *Treatment*

Participants each received 12 sessions of play therapy as outlined by the therapy manual (Woolf & Woolley, unpublished manuscript), and described briefly in the previous chapter. One of the children has continued in therapy due to ongoing care and protection concerns. Each session with the child was of one-hour duration, with parent sessions held separately at various points in the therapy program. Children were brought to therapy either by caregivers, social workers or escort drivers, who waited for the children to complete each session and returned them to school or home. Each session children's feelings and trauma symptoms were measured using the 'Feelings Chart' and 'Weekly Behaviour Report'.

### *Treatment integrity*

Treatment integrity was examined via audiotapes. A clinical psychologist familiar with play therapy and the treatment program listened to four randomly selected tapes. Assessment was made in terms of adherence to the goals and procedures outlined in the manual, alongside flexible use of the manual where required. The assessor determined that treatment was carried out in accordance with instructions in the manual.



## ***Measures***

### **Assessment**

Assessment conducted for the purposes of this research included an unstructured interview with the parent/caregiver, structured and semi-structured clinical interview with the child; parent and teacher report measures; and child self-report measures. This multi-modal, multi-method assessment was then utilised to provide an overall summary of the child's current functioning across a range of domains. In addition, weekly reports were sought from both children and caregivers/teachers in order to track changes within treatment.

### **Children's Measures**

#### *Children's PTSD Inventory*

A structured diagnostic interview, the Children's Post Traumatic Stress Disorder Inventory (Saigh, 1998) was used to ascertain a diagnosis of PTSD. The Children's PTSD Inventory is a DSM-IV based instrument, enabling the clinician to make a diagnosis of PTSD based on exposure, situational reactivity, re-experiencing, avoidance/numbing, and increased arousal. In addition the Children's PTSD Inventory provides examination of the distress caused and whether PTSD is acute, chronic, or with delayed onset. Reliability of the Children's PTSD Inventory has been examined in terms of internal consistency (.95), inter-rater reliability (.96 - .98), and test-retest reliability (87.6% agreement) at the diagnostic level (Saigh et al., 2000).

Validity has also been examined, with the Children's PTSD Inventory showing significant correlations with the Revised Children's Manifest Anxiety Scale, Children's Depression Inventory, and the Child Behaviour Checklist (CBCL) Internalising scale, and discriminant validity when compared with the CBCL Externalising scale. Taken together, these findings demonstrate the Children's PTSD Inventory to be a highly reliable and valid measure of PTSD in children (Yasik et al., 2001). However, caveats are issued that the above studies did not examine children under the age of 7 years, or children who had been abused or

neglected. As such, the present study initiates examination of the measure in this population.

### *Family Relations Test (Bene-Anthony)*

The Bene-Anthony Family Relations test (Bene & Anthony, 1985) provides an objective, reliable exploration of a child's emotional relationships with their family. Materials include 20 cardboard figures representing people of varying age, shape and gender, which fold out to form boxes with slots at the top, from which the child chooses the members of their family. A number of statements about family relationships are printed on small cards, read out one by one, and placed in the appropriate box by the child.

The Bene-Anthony is designed to measure both positive and negative attitudes towards family members, alongside parental overindulgence or over-protection. Although limited in number, results of studies regarding the diagnostic status of the Bene-Anthony appear positive. Brande (1990), in a study examining the diagnostic properties of the Bene-Anthony found that the test appears useful diagnostically, in particular providing an effective evaluation of the nature and quality of family relationships.

The Bene-Anthony was used in this study to gain an understanding of the child's view of their family, and the positive or negative relationships within this family, given the histories of maltreatment. It also provided an indication of attachment given that some children were in care, and allowed the children to acknowledge the strength and quality of relationship with both parents and caregivers.

### *Children's Self Report Measures*

Given the dearth of age appropriate self-report measures for children under the age of 8 years, two self-report measures were designed in order to attempt to follow treatment gains and reduce symptomatic concerns related to PTSD. Children completed both a weekly behaviour report and a feelings chart at the beginning of each session.

#### Weekly Checklist:

The weekly checklist was designed by the author for the purpose of this study and consisted of four symptoms identified by the child in the Children's PTSD Inventory. Children were asked to rate "how much has this been a problem for you in the last week" in one of four boxes (none of the time, some of the time, most of the time, all of the time). The weekly checklist was undertaken at the beginning of each session with the therapist in order to clarify that the questions were clearly understood by the child. An example is provided in Appendix G.

#### Feelings Chart:

As a visual analogue of changes across sessions, and also to provide a contextual link between what was happening in the child's world and feelings they were experiencing, a Feelings Chart (Appendix K) was also completed each session. The feelings chart is commonly used in assessment and therapy at SSU to gain an understanding of the child's world, and feelings associated with this world. The feelings chart consisted of four circles, which the child filled with expression of happy, sad, mad and scared. The child then rated each of the feelings on a scale of 0 (no feelings) to 10 (lots of feelings) by colouring in the scale the appropriate amount. Children were then asked what sorts of things had happened that made them feel that way.

### **Parent/Caregiver Report Measures**

Due to the age of the children in the present study a large proportion of measures required parent/caregiver report of the children's symptoms and behaviours. These measures provided both an overall assessment at the outset, and also a measure of change over time.

#### *Parenting Stress Index (PSI)*

The Parenting Stress Index (PSI) was developed by Abidin, (1995) to provide a profile of parenting across the domains of child, parent, and life stress. Scores may be considered independently and in relation to one another. Child domains include: distractibility/hyperactivity, adaptability, reinforces parent, demandingness, mood,

and acceptability. Parent domains include: competence, isolation, attainment, health, role restriction, depression and spouse. Life stress measures the amount of stress the family is currently under in terms of circumstances. The PSI provides a model of parenting based on the total stress a parent experiences in each of the domains.

The PSI has demonstrated reliability with internal consistency of Cronbach's alpha of .7-.83 for the child domain, .7-.84 for the parent domain, and .9 for total stress. Test-retest reliability across time has also been demonstrated from 3 weeks to 1 year with coefficients ranging from .55-.82 for the child domain, .69-.91 for the parent domain, and .65-.96 for total stress (Abidin, 1995).

The PSI was used in the current study as an assessment measure in conjunction with the Bene-Anthony Family Relations Test in order to establish a profile of the home environment for the child and to address any ongoing care or protection issues which may have arisen. Further, if concerns were noted after the completion of the PSI the necessary supports could be identified and implemented by case managers.

#### *Child Behaviour Checklist/4-18 – Parent Form (CBCL)*

Overall child functioning was assessed using the Child Behaviour Checklist (CBCL; Achenbach, 1991). The CBCL provides a standardised measure of parent/caregiver reports of the child's competency, emotional functioning and behaviour problems for children aged 4-18 years. The CBCL is widely used in research and clinical practice (Achenbach, 1991). Interest also exists regarding the need for NZ norms for the CBCL, and some studies have investigated this (e.g. le Roux, 2001). Le Roux found that US norms could be used with confidence, although her study was limited to children aged 11-14 years.

The CBCL consists of two sections: social competency and problematic behaviour. Social competency assesses the child in areas of activities, social, and school, as well as providing a total competence measure. The problematic behaviour consists of 118 questions utilising a 3-point scale (0 = not true, 1 = somewhat or sometimes

true, and 2 = very true or often true). The problematic behaviour questions provide a profile of behaviour in the following dimensions: withdrawn, somatic complaints, anxious/depressed, social problems, thought problems, attention problems, delinquent behaviour, and aggressive behaviour. In addition scores of some problem scales are combined to provide Internalising and Externalising scales, and addition of all items provides a Total Problems score.

The CBCL is scored on a profile form collating raw scores, percentile ranks, T scores, and the normal range and clinical cut-off for behaviours. Profile forms are separate for boys and girls. Computerised versions of the CBCL are also available and combine parent, teacher and self-report versions.

The CBCL has evidenced good reliability and validity; with test-retest reliability (.93-1.00) for mean item scores, (.9) for competence and problem scales, and internal consistency (.78 - .97), with stability proven over 12 and 24-month periods (Achenbach & Rescorla, 2001).

A recent study by Greenbaum and Dedrick (1998) revealed that the CBCL provides useful clinical information through consideration of individual symptom areas, and the total score summarising global functioning, alongside the usual internalising and externalising scores. Given evidence that maltreatment impacts on children in various ways, all areas of functioning are examined in the present study.

#### *Trauma Symptom Checklist for Young Children (TSCYC)*

The Trauma Symptom Checklist for Young Children (TSCYC; Briere, in press) is a caretaker report measure for the assessment of trauma and abuse related symptomatology in children 3-12 years. The TSCYC contains 90 items rated on a 4-point scale from 1 (not at all) to 4 (very often). The TSCYC also contains an assessment of caretaker rating style and familiarity with the child, with two validity scales to assess potential over-report (atypical response) and underreport (response level). The TSCYC contains 8 clinical scales (posttraumatic stress – intrusion, posttraumatic stress – avoidance, posttraumatic stress – arousal, sexual concerns,

anxiety, depression, dissociation and anger/aggression), alongside a posttraumatic stress total score. These scales allow for a detailed evaluation of posttraumatic stress symptoms commonly found in traumatized children alongside a tentative diagnosis (Briere et al., 2001).

Initial research regarding the reliability and validity of this measure demonstrate good reliability in a sample of generally maltreated children, in particular the scales of post-traumatic stress, sexual concerns and dissociation (Briere et al, 2001). Reliability coefficients for the clinical scales ranged from .81 (sexual concerns) to .93 (PTSD total) with an average value of .87, and were predictive of exposure to childhood sexual abuse, physical abuse and domestic violence. Posttraumatic stress scales were most predictive, followed by sexual concerns for sexually abused children, and dissociation for those physically abused. Multivariate analyses revealed sex and age differences on the TSCYC with anger scores higher for males and younger children and depression higher for older children. Initial studies indicate that the TSCYC demonstrates cross-cultural validity. Studies pertaining to the convergent validity (extent of correlation with other measures) and normative data are currently in progress (Briere et al, 2001).

The TSCYC is currently available for research purposes only, as normative data have not yet been released. Copies of the TSCYC for the purposes of this research are used with the consent of the author. For the purposes of this study, the TSCYC will be examined in terms of individual problem areas and total PTSD score.

#### *Child Dissociative Checklist (CDC)*

The Child Dissociative Checklist (CDC) was developed by Putnam (1988) as an observer report of dissociation in children. The CDC extends on a continuum from age-appropriate dissociative behaviours to the higher levels found in dissociative children. The CDC is a 20-item instrument in which the parent/caregiver circles the response on a 3-point scale (2= very true, 1= somewhat or sometimes true, 0 = not true) which best describes the child over the past 12 months.



While the CDC has performed well with children with dissociative disorder 4 years and older, reliability and validity in children younger than 6 has not been fully established as yet. In general, a score of 12 or higher should be considered indicative of significant dissociative behaviour, particularly in older children (Putnam, Helmers, & Trickett, 1993).

The CDC demonstrates good test-retest stability over one year, ( $\rho = .69$ ), good internal consistency (Cronbach's  $\alpha = .95$ ), and readily differentiates subjects with dissociative disorders from those sexually abused (Putnam et al, 1993; Putnam & Peterson, 1994). Wherry, Jolly, Feldman, Adam and Manjanatha, (1994), examined the concurrent validity of the CDC in relation to the Child Behaviour Checklist. Results indicated significant positive correlations between the CDC raw scores and CBCL Externalising, Internalising and Total scores for males, and with the Internalising and Total scores for females.

However, both the above studies focused on sexually abused children as opposed to maltreated children per se. While the link between sexual abuse and dissociative responses appears well documented, Malinosky-Rummell and Hoier (1991) suggest that future studies of dissociative symptoms should be conducted with victims of repeated physical abuse and neglect also, in order to determine the effects of various forms of maltreatment on dissociative responses. Wherry et al (1994) recommend examination of the CDC in different diagnostic groups such as those with PTSD.

The CDC was used in the present study to assess for possible dissociative behaviours in order to provide appropriate intervention, and to track change following treatment. It was also investigative in using the CDC with a younger population, who had experienced maltreatment other than sexual abuse, and with PTSD or similar symptomatology.

#### *Weekly Behaviour Report (WBR)*

In order to track changes following treatment a weekly behaviour report for caregivers and teachers was designed by the author. The weekly behaviour report



(WBR) utilised in the present study is an adaptation of an instrument designed by Cohen and Mannarino (1996c), with their consent (personal communication).

Cohen and Mannarino developed the WBR to focus on the common difficulties seen in sexually abused preschoolers. The WBR was evidenced to not only identify problem behaviours in sexually abused children such as sleep difficulties and anxiety symptoms, but also to be sensitive to change following treatment. In the present study the WBR (Appendix I) was adapted to measure symptoms of post-traumatic stress. While adjustments made affected the reliability and validity noted by Cohen and Mannarino, it was hoped it would provide some form of treatment sensitivity and monitor any changes in symptoms occurring for the child.

### **Teacher Measure**

#### *Child Behaviour Checklist – Teacher Report Form (TRF)*

The Child Behaviour Checklist – Teacher Report Form (TRF; Achenbach, 1991) was utilised to assess difficulties or problems children may be experiencing in the school environment, and to provide multi-modal assessment of children's functioning across contexts. The TRF mirrors the CBCL parent report form, and provides more detailed information regarding the child's academic performance, alongside their adaptive functioning and behavioural/emotional problems.

The TRF provides an index of current school performance across subjects ranging from 1 (far below grade) to 5 (far above grade). Also, the teacher is asked to rate the child comparatively to children their own age on the dimensions of how hard they are working, how appropriately they are behaving, how much they are learning, and how happy they are. Space is provided for narrative comment in respect of concerns for, and the best things about the child (Achenbach, 1991). The behaviour Problems Scale of the TRF match those of the CBCL parent version, and are scored on a similar profile.

The TRF has demonstrated reliability and validity, with test-retest reliability ( $r_s .9$ ) on the adaption and problem scales, internal consistency ( $r_s .9$ ) for total adaption

scale, and internal consistency (alpha .72-.95) across all problem scales. Further, the TRF has evidenced stability over time periods of 2 and 4 months (rs .7 and .6), (Achenbach & Rescorla, 2001).

Christenson, (1992) summarises that the TRF is well-designed and well-researched, providing multi-axial assessment of a child's problems and competencies. Similarly, Elliot and Busse (1992) acknowledge the TRF as an instrument with sound reliability and validity, with particular usefulness with children referred for severe behavioural difficulties.

For the purposes of the present study the TRF was obtained pre and post treatment to provide a comprehensive assessment, and to assess any changes in children's functioning within the school environment.

### ***Summary***

The present chapter details a single case methodology for the treatment of four maltreated children. A multi-modal, multi-method approach was utilised in order to provide a comprehensive assessment and treatment package and maximise effective intervention. Assessment included parent/caregiver report, teacher report and self-report from children.

## **Chapter Six: Results**

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### ***Overview***

Results are presented in terms of assessment findings regarding diagnosis or behavioural profiles, pre and post measures, and weekly measures. Given that the present study pilots a newly developed manual, the therapeutic process, in particular that of trauma focussed therapy is discussed in detail.

### ***Diagnosis***

#### **Children's PTSD Inventory**

Of the four children in the present study, only one child met criteria for PTSD according to the Children's PTSD Inventory. However, two of the other children described a number of trauma symptoms, with the third child denying the presence of any symptoms whatsoever. Thus, while PTSD diagnosis was present in only one case, in each case there were sufficient symptoms from either the PTSD inventory or parent/teacher reports of behaviour to tailor treatment in order to address behavioural concerns and trauma symptoms.

At post-treatment, participant three no longer met diagnostic criteria for PTSD as detailed by the Children's Post Traumatic Stress Disorder Inventory, although some re-experiencing and increased arousal symptoms were still noted. Summaries of the criterion areas for the diagnosis of PTSD are provided in Table 6.1.

Criteria	Case 1	Case 2	Case 3	Case 4
Exposure	+	+	+	+
Situational reactivity	+	-	+	+
Re-experiencing	+	-	+	+
Avoidance/Numbing	-	-	+	+
Increased arousal	-	-	+	+
Significant distress	-	-	+	-
Pre-treatment diagnosis	PTSD Negative	PTSD Negative	Chronic PTSD	PTSD Negative

**Table 6.1.** Post traumatic stress symptoms and resultant diagnosis as detailed in the Children’s Post Traumatic Stress Disorder Inventory (CPTSDI).

## Assessment Profile

### *Child Behaviour Checklist (CBCL) and Teacher Report Form (TRF)*

Brief summaries of the CBCL and TRF for each child provide an assessment of overall functioning in addition to diagnostic categories as obtained in the Children’s Post Traumatic Stress Disorder Inventory.

Participant one exhibited a number of problematic behaviours on the caregiver profile of the Child Behaviour Checklist (CBCL 4/18) in Total score (T = 88), Externalising (T = 70) and Internalising (T = 78) with scores within or above the clinical range on all problem scales. However, the TRF revealed high levels of academic performance and competence, with all scores within the normal range.

For participant two the caregiver profile highlighted problem behaviours in the clinical range for all areas except somatic complaints, with total score (T=81), Externalising score (T=73), and Internalising score (T=78), all in the clinical range. The TRF identified both academic performance and adaptive functioning as below the normal range. The TRF profile revealed scores in the clinical range for anxious/depressed, thought problems, and delinquent behaviour, with Internalising

behaviour indicated in the clinical range (T=69), but Externalising (T=59), and Total problem score (T=63) just below the borderline clinical range.

The CBCL completed by participant three's caregivers revealed all scores within the normal range except for Attention problems which were in the clinical range (T=70). Total Problems (T = 58), Internalising (T = 39), and Externalising (T = 52) scores were also within the normal range. The TRF indicated that although academic performance was in the normal range, adaptive functioning was slightly below normal. Total score (T=64), Externalising (T=63) and Internalising (T=63) were all in the borderline clinical range, with the problem profile Social problems reaching the highest individual level (T=70).

For participant four, the initial CBCL completed by the second caregiver revealed no elevations, and all scores were within normal range. The only concern noted by the caregiver was that of 'bad dreams'. The TRF indicated scores within the clinical range for delinquent and aggressive behaviour (T = 70 for both), and scores in the clinical range for Internalising (T = 64), Externalising (T = 79), and Total Problem (T = 71).

#### *Bene-Anthony and PSI*

The Bene-Anthony and the Parenting Stress Index have been combined to provide a summary outline of family functioning for each child.

#### Participant 1:

The PSI completed by the caregiver was only partially completed. The caregiver responded only to questions pertaining to the child domain of the PSI and not to questions pertaining to the caregiver or life stress domains. The completed child domain revealed scores in the clinical range for all domains except distractibility/hyperactivity.

The Bene-Anthony completed by Brenda indicated a strong relationship with her sister Jane. Strong positive feelings were distributed between family members, with the majority of negative feelings being attributed to "Mr Nobody". Given that

Brenda was in foster care at the time of assessment, it is possible that feelings towards family members are slightly idealised, which may account for denial of negative feelings.

#### Participant 2:

The PSI completed by Sam's caregiver revealed high scores on the child domain, but scores within the normal range on both parent domain and total stress, with life stress items not completed. Of particular significance were extremely high scores on Acceptability in the child domain (99<sup>th</sup> percentile) and Attachment in the parent domain (85<sup>th</sup> percentile). This profile is likely to reflect a poor attachment relationship between the child and caregiver, with the child seen as difficult and problematic.

Sam's Bene-Anthony showed the majority of items (strong negative, and strong positive feelings) attributed to Mr Nobody. Mild positive feelings were distributed fairly equally among Sam's siblings, with all the mild negative feelings attributed to his older sister. Sam attributed a small number of mild positive feelings to his mother and father. This profile suggests some denial or avoidance of strong negative feelings, due to the large proportion of items given to Mr Nobody, and supported by Sam's diagnostic profile indicating a denial and avoidance of any negative effects of his maltreatment.

#### Participant 3:

The PSI completed by Taylor's caregiver revealed significantly high scores (above 85<sup>th</sup> percentile) in all areas on the child domain (Distractibility/Hyperactivity, Adaptability, Reinforces parent, Demandingness, Mood, Acceptability), but scores within the normal range for all scores and total score on the parent domain and total stress score. However, the caregiver's profile also revealed a high level of life stress (99<sup>th</sup> percentile) due to health concerns, financial difficulty, and a number of deaths in the family. The profile demonstrated relatively healthy functioning of the caregivers despite significant life stress, with the high child profile indicating a child with significant behavioural and emotional issues.

The Bene-Anthony completed by Taylor indicated significant attachment to his caregivers with a particularly strong relationship with his 'dad.' Taylor's profile also demonstrated feelings of being protected and cared for with a large number of 'self' items. While some negative items were attributed to Mr Nobody, both strong and mild negative feelings were distributed evenly, with a number of negative outgoing feelings towards his siblings. Taylor attributed very few items, either positive or negative to his birth mother and father. Overall, the profile indicated Taylor to have a strong sense of self within his caregiver's family, with a particularly strong relationship to his dad, and some evidence of sibling rivalry with his brother.

#### Participant 4:

The PSI completed by Tanya's caregiver revealed scores within the normal range for Parent Domain, Total Stress and Life Stress. Overall scores for Child Domain were also within the normal range (60<sup>th</sup> percentile), but there were elevated scores for the individual items of Reinforces parent (90<sup>th</sup> percentile), and Mood (85<sup>th</sup> percentile). This may be explained by Tanya's trying to please, be good, and be 'a helper' to the caregiver. The profile demonstrates healthy functioning for both child and the child-parent relationship

The Bene-Anthony completed by Tanya indicated an equal distribution of positive feelings (both mild and strong) across all members of her family (siblings, parents, and caregivers). The majority of negative feelings (strong outgoing, and strong incoming) were attributed to Mr Nobody. This profile is perhaps reflective of a child who has idealised her world, seeing everybody in a positive light, and not wanting to acknowledge any negative feelings.

#### ***Parent/Caregiver Measures***

Results from the parent/caregiver Child Behaviour Checklist (CBCL), Trauma Symptom Checklist for Young Children (TSCYC), and Child Dissociative Checklist (CDC) are presented in table 6.2. This table shows T scores for CBCL total, externalising and internalising scores, total PTSD score of the TSCYC, and total score from the CDC at pre-treatment (assessment), and post-treatment.



Post measures from participant one were not obtained due to concerns by the parent that any results which were not favourable might jeopardise his ability to maintain custody of the children. Findings indicate little change on CBCL and TSCYC measures for participant two, with an increase in total score on the CDC. Scores for participant three indicate a reduction in total and externalising scores for the CBCL, an increase in internalising score, and reductions in both CDC and TSCYC (PTSD) total scores. Findings for participant four indicate an increase across all domains on the CBCL, although total scores are still within normative behaviour, and increases in both CDC and TSCYC PTSD total scores.

Measure	Participant	Pre-treatment	Post-treatment
CBCL Total	1	76**	N/O
	2	81**	76**
	3	58	49
	4	40	54
CBCL – Internalising	1	78**	N/O
	2	78**	72**
	3	41	51
	4	33	51
CBCL– Externalising	1	70**	N/O
	2	73**	75**
	3	52	47
	4	32	56
CDC (total)	1	6	N/O
	2	12**	29**
	3	10	4
	4	2	5
TSCYC–PTSD (total)	1	23	N/O
	2	53	54
	3	46	30
	4	15	34

**Table 6.2.** Parent/Caregiver Report Measures at pre and post treatment (\* borderline clinical range; \*\* clinical range; N/O not obtained).

**Teacher Report Form**

Results from the Teacher Report Form (TRF) are outlined in Table 6.3. Results show T- scores for Total Score, Internalising, and Externalising at pre and post treatment. Findings indicate little change across all three domains at pre and post treatment for all four children.

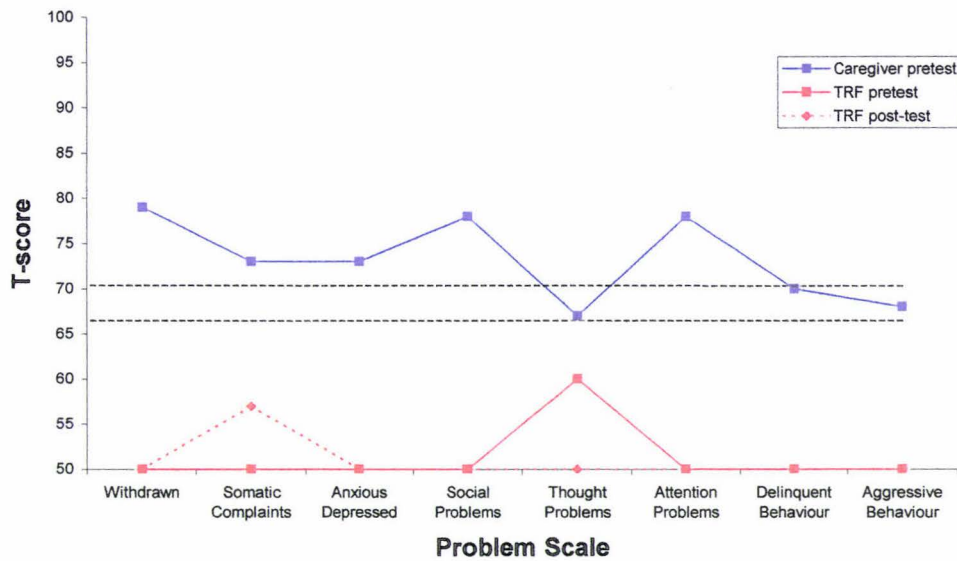
TRF – Total (T score)	1	47	32
	2	63*	65**
	3	64*	65*
	4	71**	73**
TRF – Internalising (T)	1	37	37
	2	69**	68**
	3	63	65*
	4	64**	64**
TRF – Externalising (T)	1	42	42
	2	59	59
	3	63	64*
	4	79**	78**

**Table 6.3.** Teacher Report Form at pre and post treatment (\* borderline clinical range; \*\* clinical range).

**Comparison of caregiver and teacher CBCL**

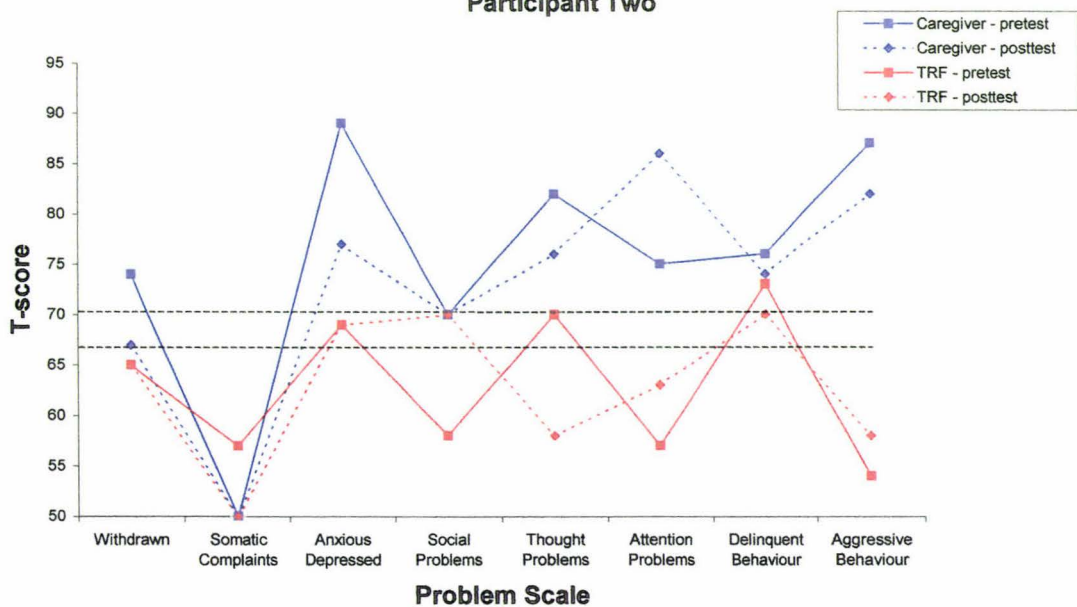
In order to more closely examine behavioural/symptom profiles of the children, comparison of parent/caregiver and teacher reports of the CBCL was undertaken. Results are illustrated in Figures 6.1 to 6.4.

**Fig 6.1 Comparison of caregiver and teacher CBCL at pre and post treatment for Participant One**



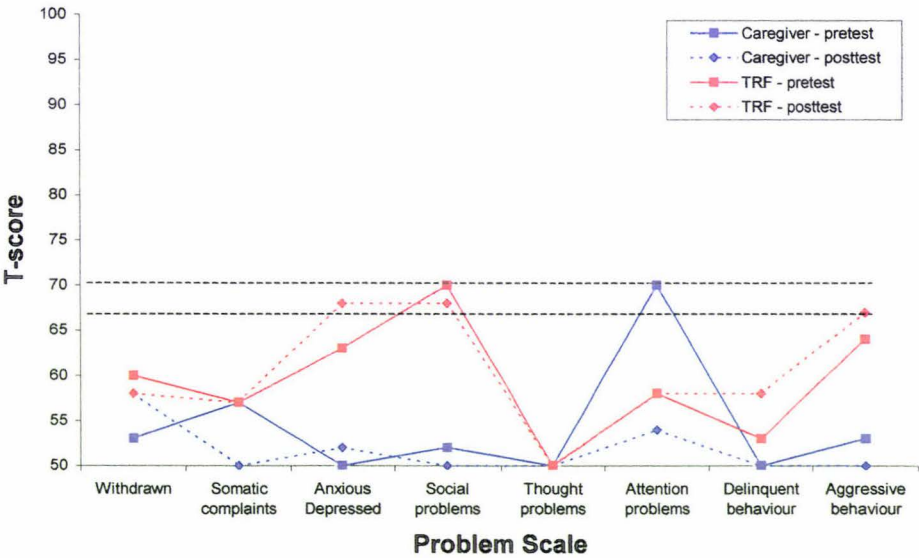
Findings indicate a significant discrepancy between caregiver and teacher reports for Participant One (Fig 6.1). The caregiver profile indicates significant behavioural concern in almost all areas, whereas the TRF indicates behaviour well within the normal limits at school. Teacher reports remain fairly consistent at pre and post treatment, with a reduction in thought problems and slight increase in somatic complaints. However, both remain within normal limits.

**Fig 6.2 Comparison of caregiver and teacher CBCL at pre and post test for Participant Two**



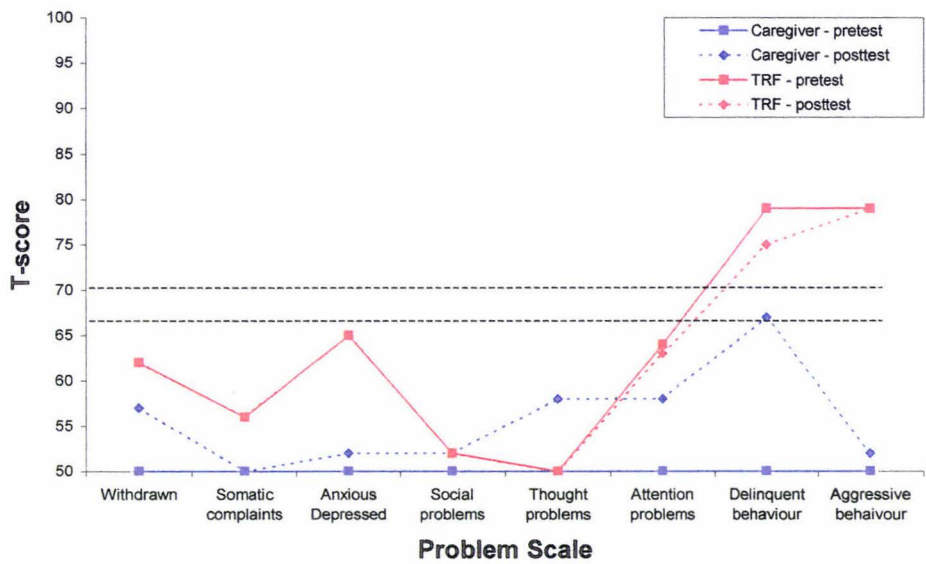
The profile of participant two (Fig 6.2) indicates significant behavioural concerns noted by the caregiver, with some agreement found on the TRF, particularly in areas of withdrawn and delinquent behaviour. Examination of changes pre and post treatment changes from the caregiver indicate reductions in a number of areas of behaviour. However, these remain within the clinical range at post-treatment, except for withdrawn behaviour. The caregiver also noted an increase in attention problems. The TRF revealed an increase in social problems to within borderline clinical range, a decrease in thought problems to normal range, and a decrease in delinquent behaviour from clinical to borderline clinical range. Anxious/depressed remained stable and in the borderline clinical range, while other changes remained within the normal range.

**Fig 6.3 Comparison of caregiver and teacher CBCL at pre and post treatment for Participant Three**



Findings for participant three (Fig 6.3) indicate mixed agreement between caregiver and teacher report, with greater anxious/depressed, social problems, delinquent and aggressive behaviour reported by the teacher. Caregiver reports indicated a significant reduction in attention problems from clinical to normal range. Teacher reports remained relatively stable with slight increases to the borderline clinical range for anxious/depressed and aggressive behaviour.

**Fig 6.4 Comparison of caregiver and teacher CBCL at pre and post treatment for Participant Four**

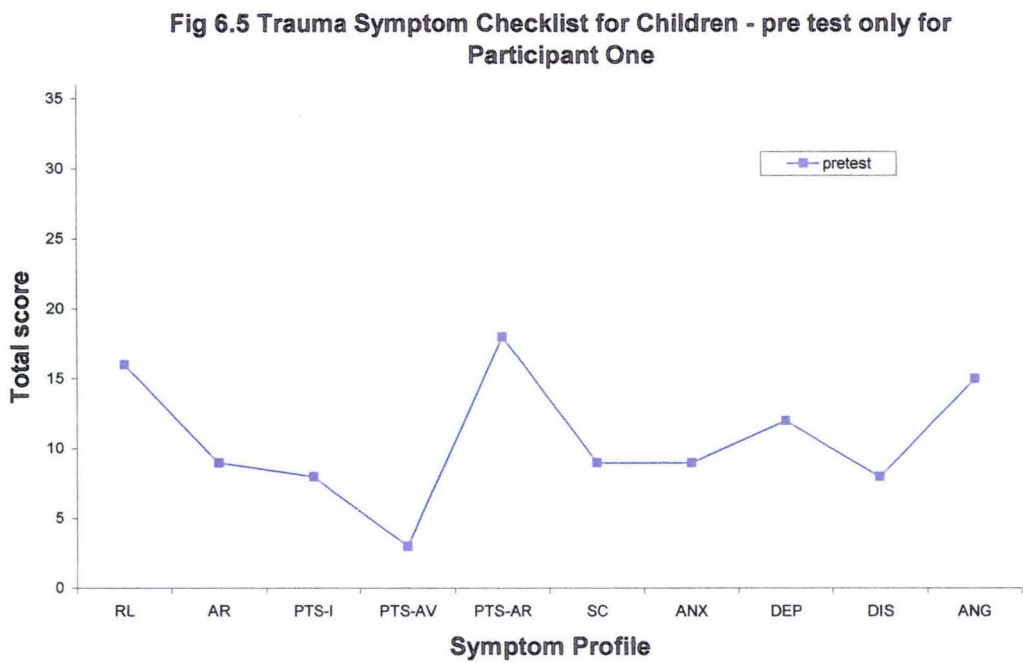


Comparison of caregiver and teacher profiles for participant four (Fig 6.4), reveal variation between caregiver and teacher reports, with some agreement on delinquent behaviour. Caregiver changes note a general increase in behaviours from pre to post treatment, with delinquent behaviour approaching borderline clinical range. The teacher profile indicates both delinquent and aggressive behaviour at clinically significant levels. Scores remains relatively stable from pre to post test, with a slight reduction in delinquent behaviour, but still within clinical range.



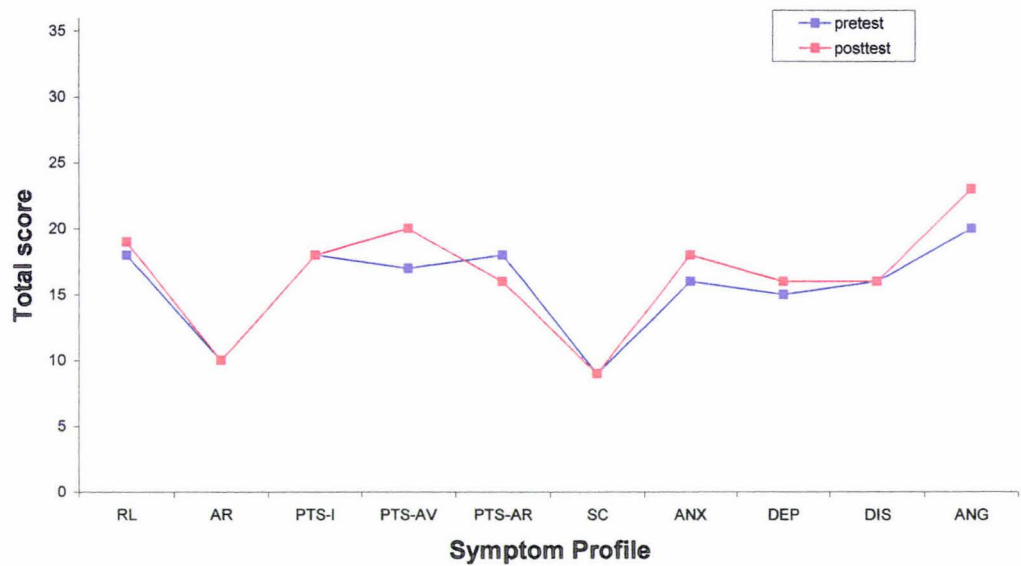
TSCYC

Alongside TSCYC – PTSD total scores outlined in Table 6.2, the TSCYC is presented in terms of individual symptom categories at pre and post treatment.

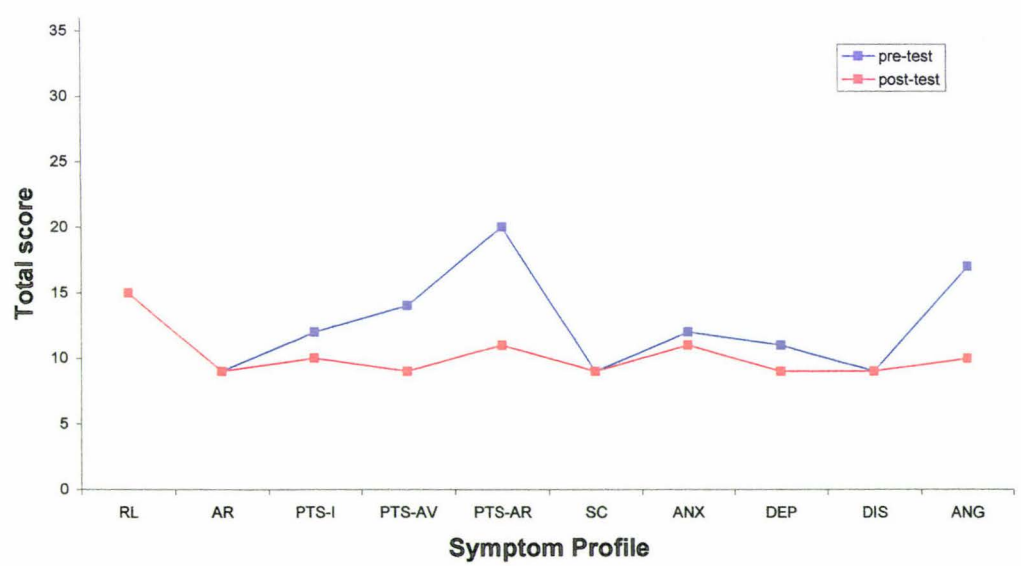


While no change in symptom profile can be detected for participant one due to lack of post-treatment measures, PTS Arousal is significantly heightened at pre-test (Fig 6.5). The profile of participant two (Fig 6.6) indicates little change from pre to post treatment across all measures. Changes across all PTS symptoms are evident for participant three (Fig 6.7), with the most significant reduction in PTS arousal. In addition, a decrease in anger was noted from pre to post treatment. For participant four (Fig 6.8), a general increase in symptoms was noted, the most significant change being PTS intrusion.

**Fig 6.6 Trauma Symptom Checklist for Children - pre and post test for Participant Two**

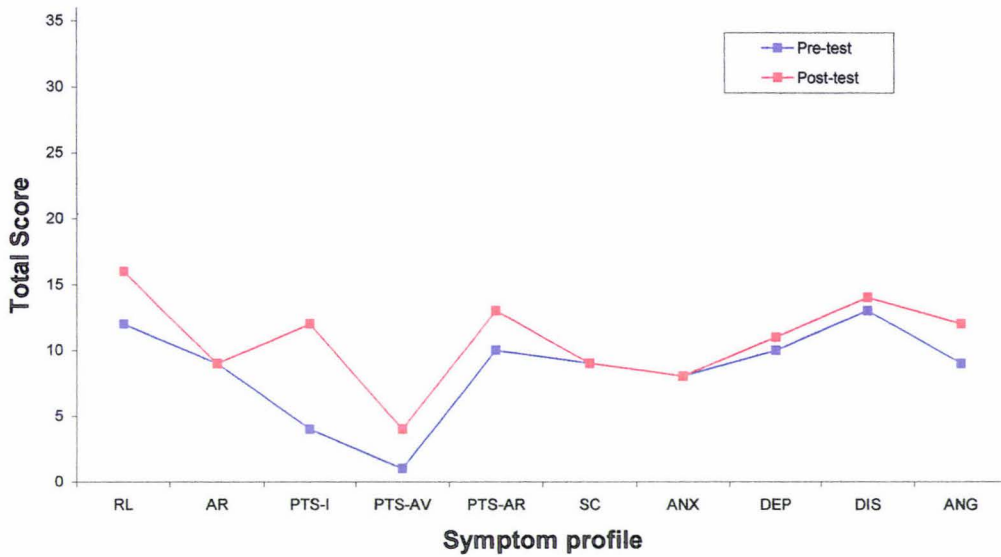


**Fig 6.7 Trauma Symptom Checklist for Children - pre and post test for Participant Three**





**Fig 6.8 Trauma Symptom Checklist for Children - pre and post test for Participant Four**



Of note across all four participants were a number of missed entries by caregivers. These missed items most often related to PTSD behaviour, in particular intrusion (re-experiencing) and avoidance.

## *Child Measures*

### **Weekly Report**

Weekly Reports (WR's) were obtained at the outset of each session with the child. Each WR was specific to traumatic symptoms reported by the child at assessment. Graphs detailing the WR's for each child are shown in Figures 6.9 to 6.11. WR's are not presented for participant two, who continued to deny the presence of any symptoms. Results of WR's for the three remaining participants reflect some variability, but a tendency for reduction in re-experiencing symptoms. The WBR for participant one reflects a reduction in trying not to think about what happened, and getting upset when reminded about what happened. For participant three reporting of symptoms in the WBR remained variable. The WBR for participant four evidenced a reduction in having upsetting thoughts about the hitting, and trying not to think about what happened, with variable reporting on the two

remaining symptoms. Three month follow-up data gained for participants one and three indicates treatment gains made at this time were maintained, as reported in this measure.

Fig 6.9 Weekly Report for Participant One

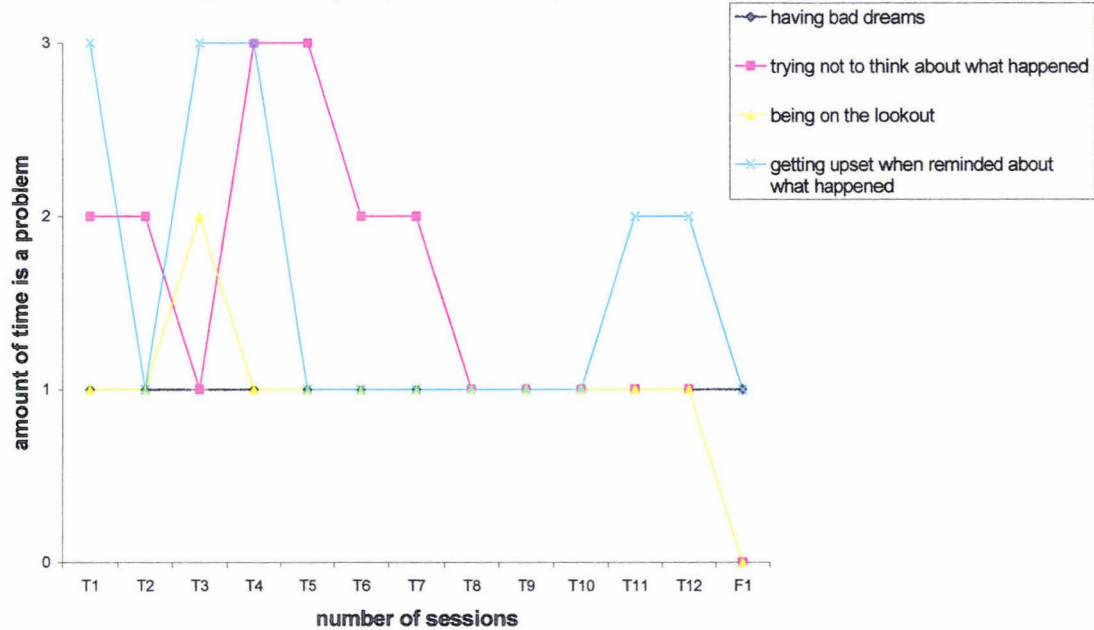


Fig 6.10 Weekly Report for Participant Three

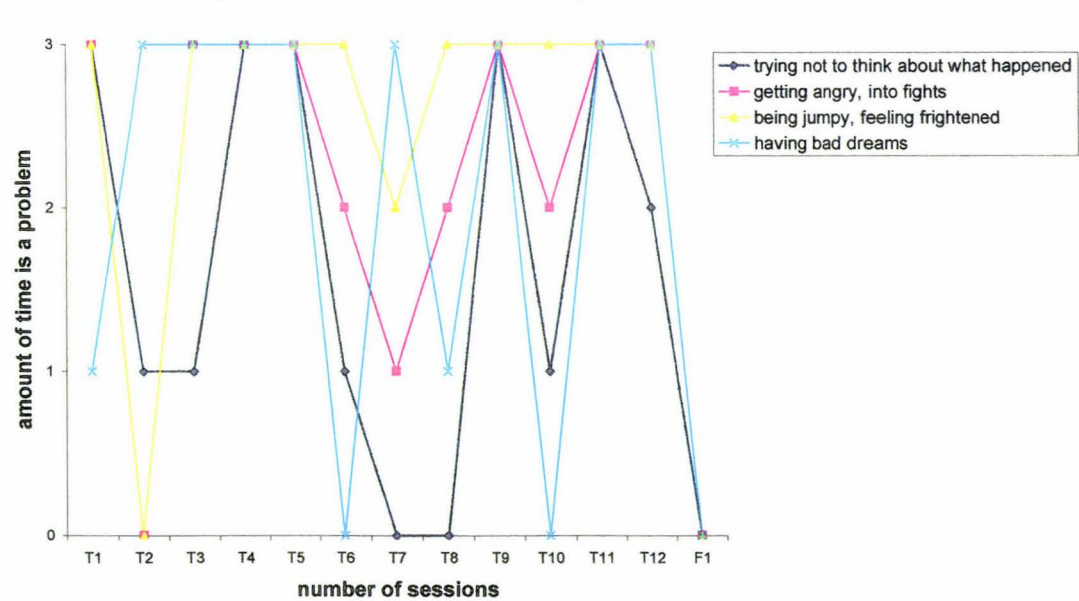
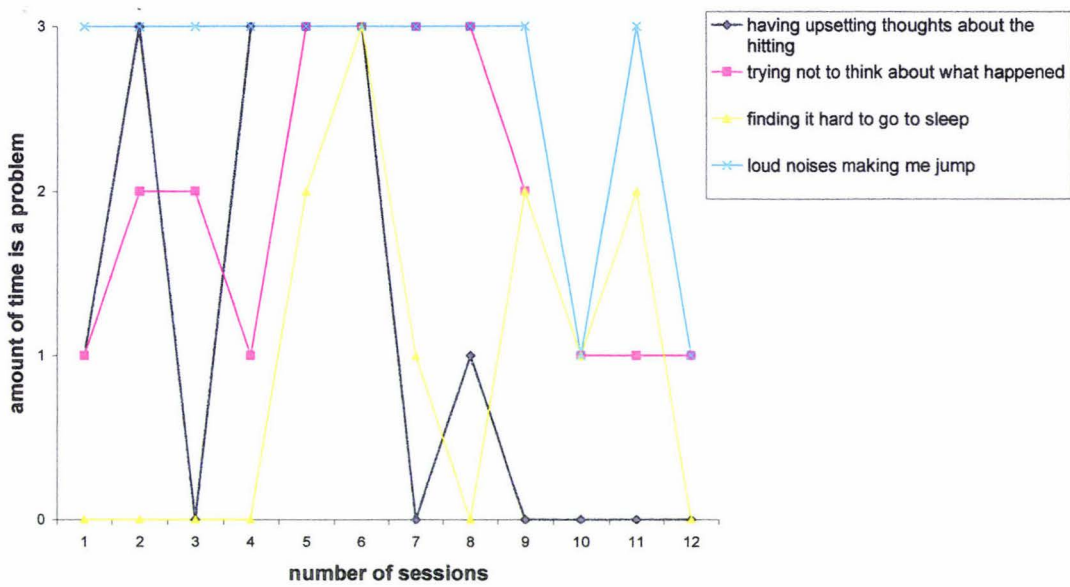


Fig 6.11 Weekly Report for Participant Four



### Feelings chart

The feelings chart provided a weekly update on things that had happened during the week, and associated feelings. Results indicated a large amount of variation in feeling from session to session for each child. The most commonly reported feeling was happy, with little reporting of scared feelings. Sad and mad feelings were often reported in conjunction with separation from family.

For participant one, sad and mad feelings were reported consistently from mid-treatment due to not seeing her mother in all this time. For participant two, happy feelings were consistently reported, with very little reporting of any other feelings. Participant three commonly reported high occurrence of all four feelings, sad and mad feelings often due to fighting with his siblings, and scared feelings to the trauma he had experienced. Participant four reported happy feelings due to going to counselling and living with the caregiver, and some scared feelings at times due to remembering the hitting, and sad and mad feelings when her brothers or children at school teased her.



## ***Therapy Process***

The following summaries provide an overview of the therapeutic process for each of the participants. In particular, the trauma processing for each child is detailed through the use of sand-play.

### **Summaries of Therapy**

#### *Participant One*

Rapport was quickly established with Brenda, who spoke freely of her worries and concerns. Brenda drew a picture of herself with a happy, smiling face, a sunshine, and love in her heart. Her three wishes included: to see her mum, to be with a fairy, and to see her dad. Brenda identified all members of her family as people in her world, and demonstrated positive relationships with each member. Her family drawing depicted everyone in the family playing soccer together. Brenda was able to identify feelings of happy, sad, mad and scared, and connect each of these feelings to things that had happened in her life. Brenda was also able to talk about different things that happened to her body when she experienced each of these feelings. Brenda was able to connect feeling, thinking and doing. In particular, she talked of what she was feeling, thinking and doing, when her mother cut her wrists. In identifying worries, Brenda said her largest worry was not seeing her mother, father, or the other children, and her second biggest was when her mother cut her wrists.

Brenda's timeline of her life involved mostly happy memories until her mum cut her wrists, and she was taken away from mum. At this time she felt sad. After being returned to her father's care with her other siblings, Brenda reported feeling happy again. Brenda identified her mother cutting her wrists as a scary thing that had happened. Brenda said that three of her older siblings were to blame for mum cutting her wrists because they were naughty and mum cut her wrists because she wasn't a good mother. Brenda reported feeling hurt, sad, scared, and mad when this happened.

In using the sand-tray for trauma processing, Brenda's initial tray "Family Beach" depicted a scene with all of her family present. Brenda chose 'Snow White' to represent herself. Symbolically, this portrayed her caretaker role within the family. Brenda placed a ghost in her tray, creeping up on Snow White, and talked about scary things, then added a grave and a dead girl. Brenda said that the black ghost in her life happened when she was in her room by herself and felt scared.

Brenda's second set of trays "Scary Island" and "Spooky Island" depicted her different feelings. The first tray placed her feelings in the sand, while the second allowed Brenda to find a solution for any unwanted feelings. Again, Brenda chose Snow White to represent herself. There were three scary things in her tray, the black ghost, an alien, and a gravestone. Both the alien and the ghost were sneaking up on Snow White. Brenda buried her 'mother' in the graveyard, but later changed her mind. This perhaps represents her fear of her mother dying, and Brenda's concern that she hadn't seen her for some time and wondered what might happen if she was drinking. Brenda said the scary ghost and alien feelings happened a lot. Brenda then poured water into the tray and spent some time swishing and smoothing the sand. This appeared to have a calming effect after talking about the scary feelings. Using the same elements Brenda worked out a solution to her difficult feelings by having a friend (Pochahontas), and a dog, help her overcome and trap the ghost and alien, and find the treasure. Her mother was unburied and discovered the stone (amethyst).

Brenda's third tray told the story of when her mother cut her wrists. Brenda described the incident from start to finish. The sand tray was set up to look like the house, with a lounge, kitchen and bathroom. Brenda described all that had happened, and the roles that each of her siblings had played. Brenda said she had stayed with her mother in the bathroom and that her mother had said, "I'm not a good mother". Brenda reported feeling nervous talking about what had happened, and had sad, mad, and scared feelings remembering it. Brenda used the sand to create another tray with her mother in the kitchen and the children doing various tasks as a way to debrief from this session.

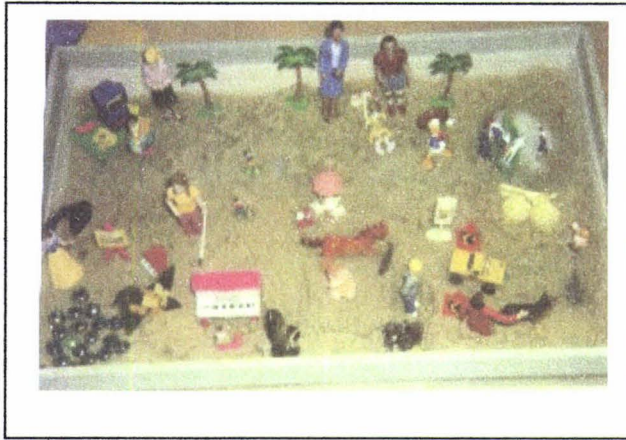
In her fourth and final sandtray, called “Snow White’s Castle”, Brenda depicted her future world. Brenda enjoyed the messy play and spent a lot of time wetting the sand and swishing and patting it into place. Brenda’s tray had Snow White with her animals. She had a mother (in the kitchen), helpers (the dwarves), and lots of cats. Brenda described the castle as fun, and talked about the buried treasure, asking the therapist to guess where it was.

In free play Brenda often chose interactive crafts or games with the therapist and interacted freely talking about school, things that happened at home, and her thoughts and feelings about her mother and father. When Brenda had returned to her father’s care there was a marked change in her demeanour and she appeared much happier and enjoyed sharing with him and her siblings the activities, which had been undertaken in session.

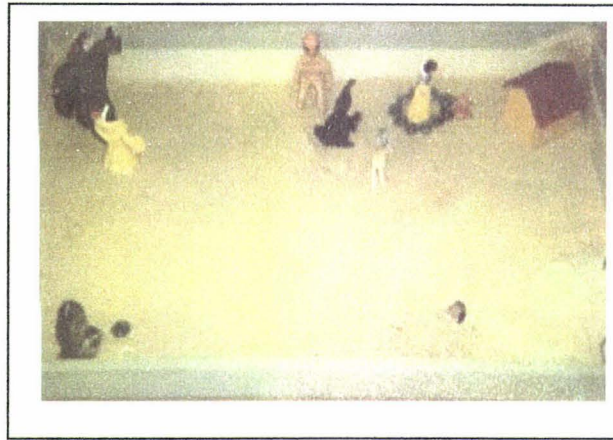
In her final session, Brenda said that she liked the sand-tray the most, and paper people. She said the worst thing was homework. Brenda said that she no longer had as many bad dreams, and that things were better now she was with her father, but she still felt sad and mad about not seeing her mother.



Figure 6.12 : Sand-tray Process for Participant One



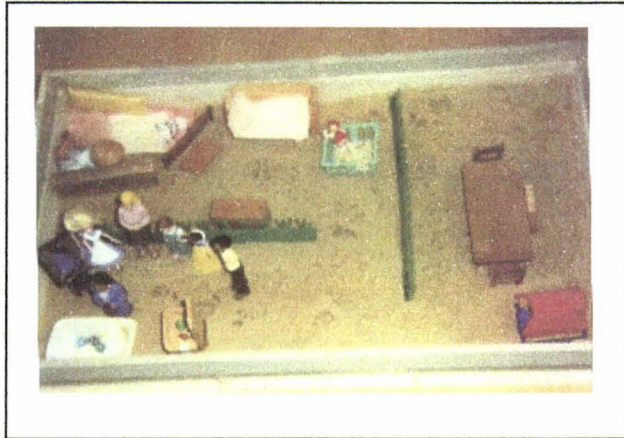
Tray 1: World Tray "Family Beach"



Tray 2a: Feelings Tray "Scary Island."



Tray 2b: Feelings Tray "Spooky Island"



Tray 3: Trauma Tray (untitled).



Tray 4: Free Tray "Snow White's Castle"



### *Participant Two*

Sam participated willingly in therapy and was easy to engage although often was distracted and moved from activity to activity. Sam's free play often reflected play in younger children such as a focus on pouring (sand, water, glitter, glue), and play with play-doh and other tactile elements such as sand and clay.

Sam drew a picture of himself that showed a somewhat frightened face and said his three wishes were for a dog, a cat, and a mobile phone. Sam's picture of his family included all his family playing with cars. However, each person in the family was depicted as a stick figure, and he and his sister had heads but no bodies. This perhaps reflects Sam's sense of disconnectedness from his family. Sam talked fondly of his parents and grandparents, saying that they always get them stuff and play with them.

While Sam was able to draw happy and sad faces, he was unable to differentiate between mad and scared faces, or to acknowledge any sad, mad, or scared feelings ever happening to him. Sam found it difficult to make connections between feeling, thinking, and doing. In talking about worries Sam said his biggest worries were people coming and fighting him at school and being pushed off the playground.

Sam was unable to complete the time-line or think of times when he had different feelings in his life. Sam reported feeling happy when he was born, and went to school, but that he had not felt scared or sad. In the paper people activity Sam placed plasters on everyone saying they all felt sad when they left mum and dad (at access). Sam said the hitting was his sister's fault, as she had taken something she was not supposed to, and that everyone was mad at his sister. Sam said he felt scared when he left his mum and dad. Everyone in Sam's family was described as a helper as they give him stuff, like presents and food.

The initial "world" tray created by Sam was called "Dragonball Z." Sam spent a great deal of time creating and adding to his tray, which is full of many objects. Central to this (and other) trays is the Dragonball Z character whom Sam identified

with as he can fight and change stuff. Other key symbols for Sam included the gravestone and the wizard (who makes dreams come true). A central theme observed during the creation of the tray was Sam's desire to "fill up" his world with as much as possible, and a difficulty creating and keeping to boundaries (such as limits placed on items to be added to the tray). Sam's story involved busting down the old world and making a new, funny world.

Sam's feelings trays were titled "Happy and Sad Feelings" and "The Sandpit World". In the first tray, Sam's scared feelings were the black ghost, the grave and the mirror. Sam chose the wizard for his happy feeling and said this was his strongest feeling, and that the wizard had the power of life. He said the feeling he felt most was the alien (sad) and the feeling that happens the most at home was the black ghost (scared). He said he would most like to be one of the builders, because they are not naughty they only build things. Sam then went on to create a more busy, full world with his key characters (Dragonball Z, the wizard, the gravestone, the mirror, the amethyst), alongside household items and cars.

In addressing the scary thing that had happened to him in the sand-tray, Sam stated he did not want to put scary things in the tray. Sam was then directed to make a tray of whatever he chose. Sam was much quieter than usual in the creation of this tray, and began by placing boundaries firmly in place, perhaps an indication of his unreadiness to address his trauma. However, in doing this, the 'trauma tray' is more controlled and organised and shows less chaos than other trays created by Sam. Sam called the tray "Christmas is Cool", again perhaps reflecting his need to distance himself from remembering the trauma and focusing on positive and happy memories. Many of the same elements were used in the creation of this tray as in earlier trays.

The fourth and final tray created by Sam saw a return to his need to 'fill' his world, and in fact Sam used two trays to create his scene, with what could not fit in the first tray being placed in the second. Again, Sam was unable to place boundaries, either in the tray, or keep to boundaries and limits directed by the therapist. Sam enjoyed filling his trays smiling and saying, "I'll make you have more work." Sam's dry tray was "all the people what came back to life" and his wet tray "all the

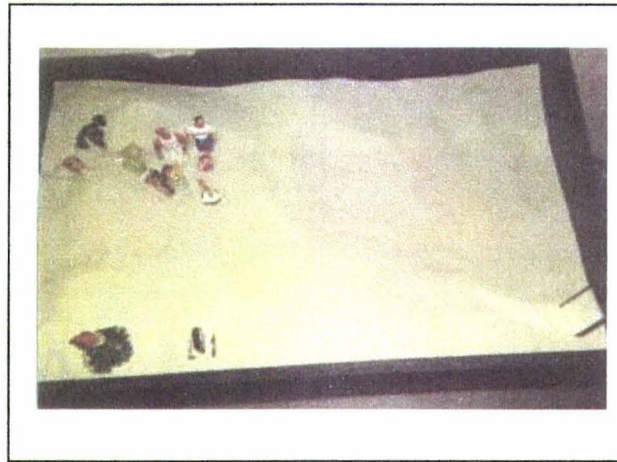
stuff what comes back to life.” In his final session, Sam said that nothing helped the most, and that the best thing was everything. He said there was nothing that he did not like, but could not think about things that had got better or changed.



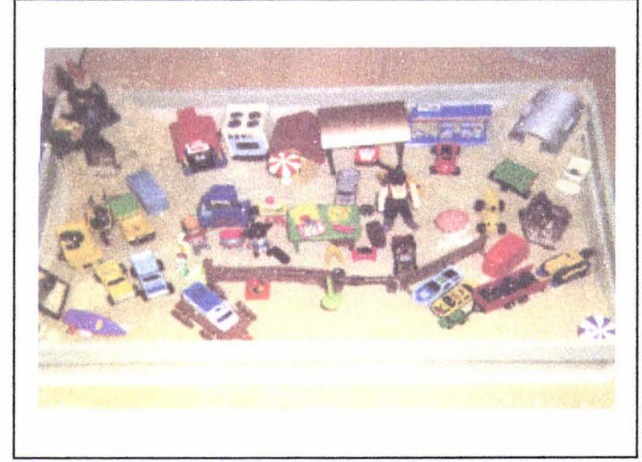
Figure 6.13 : Sand-tray Process for Participant Two



Tray 1: World Tray "Dragonball Z."



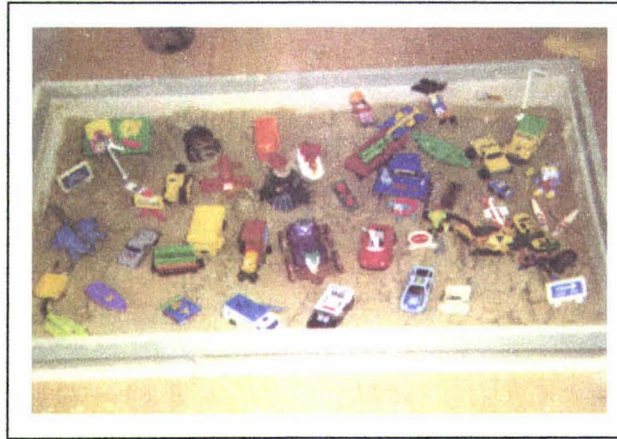
Tray 2: Feelings Tray "Happy and Sad feelings"



Tray 2b: Feelings Tray "The Sandpit World"



Tray 3: Trauma Tray "Christmas is Cool."



Tray 4: Free Tray "All the People and all the stuff that comes back to life..."



### *Participant Three*

Taylor was eager to enter the playroom environment and enjoyed playing with the many toys in the playroom. At times Taylor was distracted and found it difficult to remain on task and complete activities, preferring to move from toy to toy and to play with the games. Most of Taylor's free play involved playing games with the therapist. However, Taylor often found it difficult to engage in the rules of play, preferring to win the games and change the rules in order to have his own fun. Taylor demonstrated good rapport with the therapist, painting a picture of himself and the therapist in an early session.

Taylor drew a picture of himself, and said his three wishes were to go to heaven, to be magic, and to play in the sandpit. Taylor's family world consisted of his caregiver 'mum' and 'dad' and his real mum and dad, and God. Taylor identified positive feelings to all members of his family, but scared feelings of his brothers whom he sometimes fought with. A picture of his family showed them all in the pool, with Taylor clearly on the side of his caregiver's family, with his mother and sister some distance away. Taylor was able to draw both happy and sad faces, but was unable to clearly differentiate between mad and scared. He was, however, able to talk about things that made him feel, happy, sad, mad or scared. He was able to make the connection between feeling and doing, but not able to find examples of what he might be thinking in connection with different feelings. Taylor identified his biggest worry as 'Ben beating me up' and other worries as his brother being mean, kids at school being mean, and being in a room by himself.

The timeline completed by Taylor showed many periods of feeling happy, except when he was hit by Ben, at which time he was scared and crying, and Ben had an angry face. He said he was also happy living with his mum N (caregiver). At the time of the trauma, Taylor said that he was the one who was hurt, and that Ben was to blame as he did the hitting. He said that he felt mad and scared when he got hit, and that there were no helpers, only him.

The first sand-tray completed by Taylor was called "Dragon World". This tray depicted a number of scary animals (spiders, bats, wild animals, snakes) scattered



through the tray. There were also a number of pieces of food (sandwich, pie, drink). Taylor's creation of the tray followed a pattern, first marbles, then food, and then fighting elements, then animals. Taylor remained focused when creating his tray but was unable to tell the story of what was happening.

Taylor used two trays to depict his feelings, "Water World" and "Dog World." The first tray consisted of the feelings directed by the therapist, the second tray his own free play. In the first tray, the strongest feeling, Hercules (happy), kills people (black ghost, wizard and ant – scared feelings) with the help of his dad (Zeus). Taylor said that the scared feelings happen the most at school and at home, and that he would like to be Hercules so he could make the ghost and the ant go away. In this tray Taylor reveals the dominance of scary feelings in his life, but shows a sense of strength and a strong identification with a father figure in order to overcome these.

In addressing the trauma due to the hitting which happened Taylor created a further two trays – "Dolphin World" and "Triceratops World". In creating his trays Taylor scooped entire shelves of objects into the basket, but did not use all he had chosen in his trays. He was distractible and moved quickly, wanting to finish and take a photo. Taylor chose a dog for himself, and dogs for his family of helpers. He depicted Ben as a cow, and his helpers were all the rocks. Taylor then created the tray with the dinosaurs.

In his final trays "Hercules World" and "Good World" Taylor completed a process of identifying his own strength and re-inventing his story. Taylor chose the figure of Hercules to represent himself, but took some time to choose a figure for Ben and enlisted the therapist's help. Eventually Taylor decided on the Dragonball Z character because he was muscly and strong. Together the therapist and Taylor explored Ben's character and that of Hercules, focusing on what things might help Hercules, such as a sword and shield. Taylor also went on to talk about what had happened and that Ben had got into trouble for hurting him. Taylor's second tray "Good World" depicted a world without Ben, and no more scared feelings.

The final session with Taylor involved lots of playing of fun games, which Taylor particularly enjoyed. Taylor said that the best thing was the sand-trays and the worst thing was the bubbles. When asked if anything had changed or got better, he said working here, however, when asked if his worries about Ben had gone away Taylor replied 'no'.



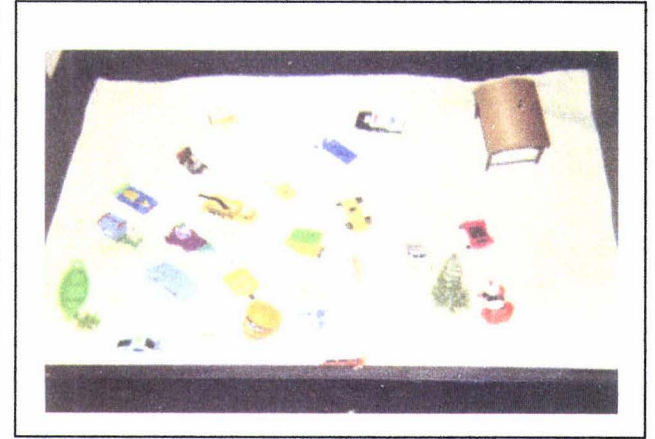
Figure 6.14 : Sand-tray Process for Participant Three



Tray 1: Make a World "Dragon World"



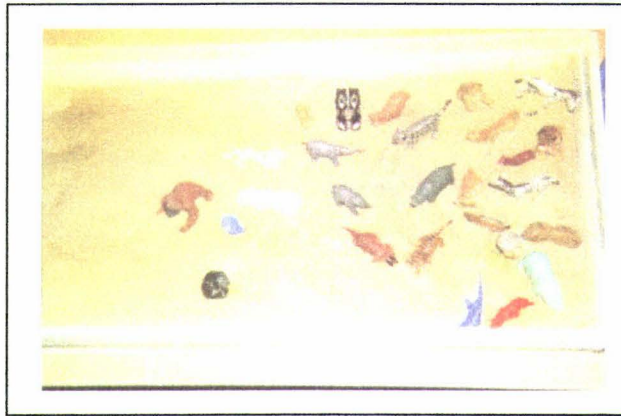
Tray 2a: Feelings "Water World."



Tray 2b: Feelings "Dog World"



Tray 3a: Trauma Tray "Dolphin World."



Tray 3b: Trauma Tray "Triceratops World."



Tray 4: Free Tray "Hercules World"



Tray 4b: Free Tray “Good World”

#### *Participant Four*

Tanya settled quickly to therapy, was easy to engage and enjoyed both structured activities and free play. Tanya drew a picture of her face as happy and smiling. Her three wishes were to have a birthday every day, to do art, and to have wishes all the time. The people in Tanya’s world consisted of her brothers and sisters, alongside her caregiver and all the other children living in care. Tanya did not put her mother and father into her world, but when questioned, put her father inside her world, and her mother outside the world. Tanya identified feelings of love toward all the people in her world, angry feelings to her brothers who sometimes annoyed her and fought with her, teddy bears for her helpers, her caregiver, two older girls in the house, her baby brother and sister, and her father. Tanya’s picture of her family consisted of her caregiver, Joyce, herself, her two brothers (also in care) and another child in care.

Tanya was able to draw happy, sad, mad and scared faces. Tanya was able to identify different times she had felt each feeling, and in particular talked about feeling mad when her mum hit her, and scared when the hitting happened. Tanya was able to connect feeling, thinking, and doing, and talked about this in relation to her mother hitting her, thinking that her mother was terrible and not wanting to see her again because ‘she might hit me again’. Tanya talked about her biggest worry as being her mother hitting her, the next as staying home and looking after the babies by herself, then mum and dad arguing, and kids teasing her at school.



In Tanya's timeline of her life she reported happy feelings when she was a baby, and when living with dad, at Janice's (caregiver), at Joyce's (caregiver), and her recent birthday. Tanya reported feeling sad when mum did the hitting, and when her stepfather hit her little brother when he was drunk and her brother was bleeding. Tanya talked about the police being rung on both occasions. Tanya said there was lots of hitting until she was six, and that it was worst with mum. Tanya's paper people showed herself as hurt because of the hitting which happened, and her siblings as sad. Tanya placed three sticky dots for blame on her mother, saying it was her fault as she did the hitting. Tanya also said she was mad and scared because of the hitting. Tanya identified her helpers as Dad, her little brother and sister, and her caregiver.

Tanya's initial tray, "The Hunchback of Notre Dame" depicted a relatively full world, complete with houses, trees, animals and household items. Tanya chose Snow White to represent herself. Tanya's story of her tray consisted of descriptions of the different things that were happening in her tray, for example, "the horses are around Snow White."

The feelings tray created by Tanya included a spider for sad feelings, and a snake and a bat for scared feelings. She identified the fruit box as happy feelings, and said happy feelings happened at school, at her dad's and at the caregiver's house. Tanya was unable to name her tray, and said she would like the bad feelings to not be there anymore. Tanya then buried the bad feelings in the tray, which changed her tray to one of happy feelings. In these two trays Tanya identified with the Minnie Mouse character.

Tanya worked through her trauma in a series of three trays called "Badland," "Goodland," and "Minnie Mouse Land." Badland depicted the scene where her mother had hit her. Tanya talked through what had happened and her scared and mad feelings at the time. When asked what would make the tray feel better, Tanya proceeded to bury her mother under the sand, saying, "now it's better." Tanya said it felt better because "now mum won't hit me anymore." Tanya then chose to make a further tray depicting a happy scene with a house, treasure, and fun activities

(piano, computer, art table). This tray may indicate Tanya's desire for a safe and happy home, with no further hitting.

Tanya's final tray was called "Horseland." This tray showed lots of horses "going round and round in circles." The tray showed some of Tanya's strength and resilience with the horses being a symbol of strength and happiness for Tanya, and different horses representing different people in her life (siblings, caregivers, therapist). The tray also contained lots of treasure, which she had found, and the fun activities from a previous tray.

In free play Tanya often chose to talk and play interactively with the therapist, playing games, making play meals, or drawing together. In her final session, Tanya said the thing that helped the most was "talking to you," the best things was "getting prizes and seeing you," and the worst thing was "not coming every day." When asked what had changed or got better, Tanya said that the bad dreams, the scared feelings, and the hitting thoughts had gone away.



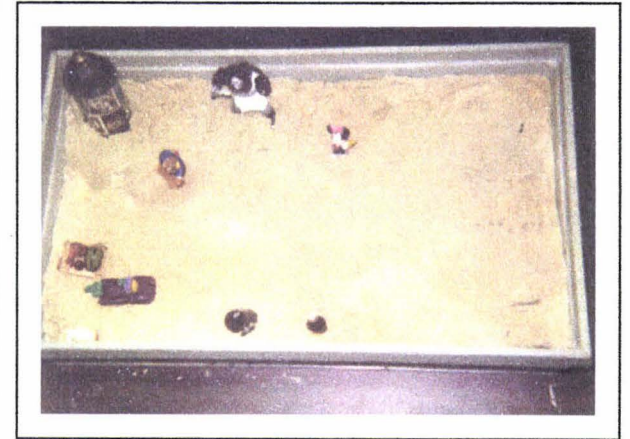
Figure 6.15 : Sand-tray Process for Participant Four



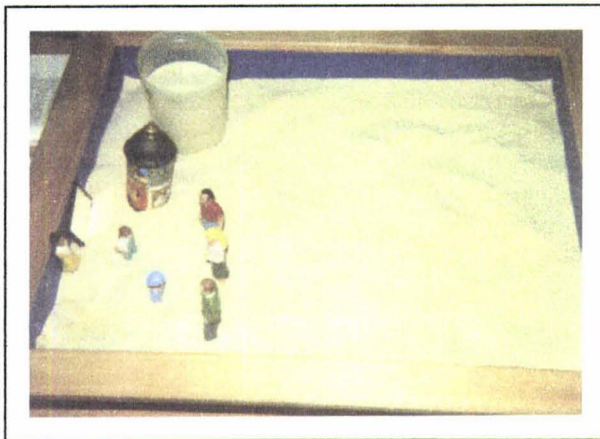
Tray 1: World "The Hunchback of Notre dame"



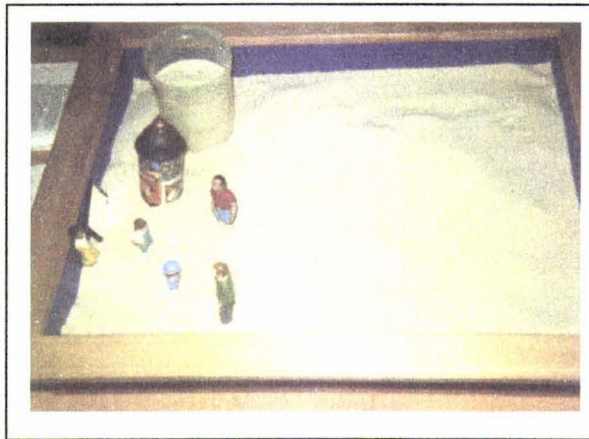
Tray 2a: Feelings (untitled).



Tray 2b: Feelings (untitled)



Tray 3a: Trauma Tray "Badland."



Tray 3b: Trauma Tray Goodland."



Tray 3: free-play tray – Minnie Mouse Land



Tray 4: Free Tray “ Horse land”

### *Summary*

In summary, results suggest some variability in findings, with children’s self-report measures showing the most variability. Discrepancies between caregiver and teacher reports were also evident, with the most change observed by caregivers, and little observed by teachers. While children’s self-report measures showed fluctuation, feedback from children, caregivers and the therapeutic process indicated that some level of trauma processing had occurred for these children.

Changes following treatment could not be verified for Participant One. However, feedback and some self-report measures indicated a reduction in symptoms. Relatively little change was observed in Participant Two, and he continued to deny any negative symptoms throughout treatment. Participant Three showed the most change, no longer meeting criteria for PTSD at post-treatment, and showing reductions in a number of trauma behaviours. For participant four there appeared to be an increase in symptoms as reported by the caregiver and some self-report measures, although feedback and the therapeutic process indicated a working through of trauma and reduction in symptoms.



## **Chapter Seven: Discussion**

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### ***Overview***

The following chapter discusses the findings of the present study. Firstly, a summary is presented, detailing the diagnostic and symptom profiles of the children in the study. Based on these findings, the utility of the treatment manual is discussed. Following this, strengths, limitations, and issues/complexities are highlighted, with particular reference to clinical implications and future directions.

### ***Summary of Findings***

#### **Assessment**

The multi-modal assessment undertaken evidenced that maltreated children present with a complex array of symptoms and difficulties. A key factor in gaining a comprehensive assessment, is information gained from parents or caregivers. The assessments undertaken in this study were at times limited where caregivers were unable to provide an accurate representation of the child's symptoms or progress in therapy. This may in part be due to the caregivers not having an awareness of the child's developmental history, caregivers having a number of children in their care and limited time available to focus on the needs of one child, frequent change in care-giving arrangements, and the masking of the child's behaviour and symptoms due to the need to settle and adjust to the care-giving environment. These concerns are highlighted in the current study where there were at times marked discrepancy between child and caregiver reports, where caregiver reports of child behaviour showed increased behavioural concern over time, where behaviours exhibited at the caregivers were no longer present when children returned to the care of their family, or where behaviour deteriorated due to the re-introduction of family members.

Given the significant number of behavioural concerns for these children outside of PTSD type symptomatology, the study would have been strengthened by the inclusion of structured clinical interviews to gain a more comprehensive



assessment of functioning and other possible diagnoses such as ADHD, anxiety disorders, depression, or separation anxiety disorder. However, such assessments are complicated when children are removed from the care of their parents, as a diagnosis such as separation anxiety disorder is highly likely, given that children are suffering some distress at being separated from family they may also present with symptoms of anxiety and depression, or externalising behaviours.

## **Diagnosis**

Only one child met criteria for PTSD as assessed by the Children's Post Traumatic Stress Disorder Inventory. However, participant four failed to meet diagnosis only due to lack of reporting significant distress. As the Children's PTSD Inventory is a systematic interview, children who fail to meet criteria in one area are not further assessed. Given the behavioural profiles of these maltreated children, the Children's PTSD Inventory was fully administered. Examination of the interview profiles reveals that children exhibited a number of symptoms in each of the categories, but these were not always sufficient to meet diagnosis. Such findings are in agreement with Carrion et al (2002), who found children with subthreshold PTSD demonstrated substantial functional impairment and distress.

The children in this study did tend to exhibit more re-experiencing and avoidant symptoms, as suggested by McNally (1993, as cited in Putnam, 1997). McNally further suggests that this may be due to inadequate structured interviews and assessment techniques for children. In completing the Children's PTSD Inventory, all four children had difficulties with the concept of time, particularly with how long a particular symptom had been experienced. Thus, for some children, a negative diagnosis may be obtained when PTSD is in fact present. Consequently, it is important to consider PTSD as dimensional in nature as proposed by Putnam (1997). It is for this reason that children were included in the study if they had experienced trauma and were exhibiting partial forms of PTSD, or other problematic behaviours.

Findings support current concerns regarding the applicability of DSM-IV based PTSD diagnosis in maltreated children, as outlined by Putnam (1997). This may be

due to the age of the children studied, and the difficulty in their understanding of concepts necessary for a true diagnosis of PTSD, or may reflect inadequacies in the structured interview for maltreated children under the age of eight. Of particular importance may be the necessity to make a distinction between complex trauma, as often experienced in maltreatment, and single incident trauma. It may be that children are more able to answer questions regarding a single incident trauma, where memory of time and place are more contained, than recalling incidents of abuse, where it is likely that such events have occurred over time and since a young age. Children who have experienced ongoing and multiple abuse, may find it difficult to answer questions regarding how long certain symptoms have occurred, or to separate out what symptoms have occurred in response to different trauma.

### **Trauma symptoms and behavioural profiles**

#### *Child Behaviour Checklist*

Results outlined in Table 6.2 indicate little change for participants 1-3 at pre and post treatment as observed in the CBCL in terms of total problem, internalising, and externalising behaviour. However, for participant four there was an increase in observed symptoms on these measures. Examination of the individual problem scales of the CBCL supports these overall findings. Consideration of PTSD as an anxiety disorder indicates that the majority of change following PTSD specific treatment is likely to be reflected in anxious/depressed behaviour. However, such changes were evident only for participant two, where a decrease was reported in anxious/depressed and withdrawn behaviour.

Examination of CBCLs from caregivers and teachers reveals a wide variety of behavioural symptoms for these maltreated children, with social problems, aggressive or delinquent behaviour, and attention problems relatively common, at borderline or clinically significant levels. Three of the children were experiencing significant problems in the school environment, with teachers reporting disruptive behaviour and learning difficulties.

This profile appears to fit with the association between PTSD and ADHD type behaviour (Famularo et al, 1994; Glod & Teicher, 1996; McLeer et al, 1994). A number of explanations for this association are possible. Children who have been maltreated may spend time and attention attempting to avoid or manage the re-experiencing or intrusive thoughts and be unable to attend to other matters. Alternatively, maltreated children may develop ADHD like symptoms due to their home environments. For example, the effects of the first three years of life on subsequent neurodevelopment, a learned response to be alert to danger in the environment at all times and subsequent difficulty in concentrating, or even the effects of poor parenting/neglect, where boundaries have been unclear and children have not learned to relate to others or abide by rules.

#### *Trauma Symptom Checklist for Young Children*

The TSCYC was used as a parent report measure to validate the structured diagnostic interview utilised with the children. Examination of the TSCYC profiles reveals a significant reduction in reported symptoms for participant three, consistent with pre and post assessment from the Children's PTSD Inventory. As such, the TSCYC appears to measure PTSD symptomatology as observed in the four children in this study. Participant three (who met diagnostic criteria for PTSD) evidenced the most change in post traumatic stress symptoms (intrusion, avoidance, and arousal) as measured by the TSCYC.

These findings appear to indicate that both the TSCYC and Children's PTSD Inventory are measuring the same construct. Such findings also indicate that the treatment manual appears most effective with children who present with significant post-traumatic stress symptoms. It is possible that lower levels of initial reporting of trauma symptoms minimise the observed impact of treatment, particularly where behaviours are within normal limits.

However, caregivers tended to under-report possible PTSD symptoms as evidenced by numerous missing items on the TSCYC for re-experiencing and avoidant behaviour. This tendency of under-reporting by parents is further exacerbated in the present study due to all four participants residing with

caregivers, with a limited ongoing or long-term overview of the child's functioning. This finding is consistent with research stating that parents/caregivers often under-report symptoms in children (AACAP, 1998), and validates the need to directly question even young children regarding their symptoms and behaviours (Davis & Siegel, 2002; Yule & Canterbury, 1994).

#### *Child Dissociative Checklist*

The CDC was used in order to assess and measure change in dissociative symptoms for the four participants. The CDC appeared to accurately reflect dissociation in these younger maltreated children, with participant four showing the highest level of dissociative behaviour at a clinically significant level, consistent with other measures reflecting his own denial of negative feelings and behaviours, and reports from caregivers and teachers of significant behavioural concerns. The CDC was also able to track change for participant three, where a reduction in dissociative symptoms was observed. As the CDC has not been validated with this particular population, results appear to indicate this instrument is an effective measure of dissociation in younger children who have been maltreated, although further research with larger samples would be necessary to validate this finding.

#### **Clinical significance and observed change**

Examination of the findings reveals the most significant change occurred for participant three, the only child who met diagnostic criteria at assessment. As such, this may suggest that the play therapy manual works best with children who meet diagnostic criteria. Informal feedback from children and caregivers did suggest that children experienced fewer traumatic symptoms, although these reports are not supported by measures obtained which tend to indicate little clinical change, or for some children, an increase in some symptoms.

While weekly behaviour reports obtained from the children evidence a significant amount of variability, this may be a reflection of the difficulty of developing valid and reliable self-report measures for children of this age. As discussed earlier,

children in the present study experienced a difficulty with the concept of time, a concept often necessary in obtaining evidence of treatment sensitivity.

A further difficulty in obtaining observations of change, were frequent changes in care-giving environments for these children. It is interesting to note that the most change was observed for participant three, where his caregivers remained stable throughout treatment, and permanency in care was obtained during treatment. All three other children either experienced a change in caregiver, or a sense of uncertainty regarding the future and where they would live.

Alternatively, a discrepancy between caregiver informal report of change, and that obtained from caregiver/teacher measures may indicate a 'lack of fit' between report measures and observed change. Maltreated children tend to present with a complex array of symptoms. While treatment specific to PTSD may alleviate some of these symptoms, other remaining behavioural concerns may cloud the treatment picture, suggesting little clinical change, when in fact treatment gains have been made and observed within sessions.

A key difficulty in the present study was accurately measuring change across treatment. The variable nature of reporting by the children indicates that for children of this age, such self-report measures may not provide a reliable source of monitoring of symptoms.

While the feelings chart did not prove useful as a treatment sensitive measure, it did provide imperative information of the child's daily world. For example, participant one was able to document the changes in caregiver arrangements, her happiness at being back with her dad, but her sad and mad feelings about not seeing her mother. The feelings chart also provided information about issues or worries occurring for children at school such as bullying, being picked on, or not having any friends. Thus, although not yielding reliable information for 'research' purposes, the feelings chart was a useful clinical tool, and provided a springboard for children to talk about feelings and things that had happened during their week.

Concerns as to the ability of children to accurately report symptoms prompted the inclusion of parent/caregiver and teacher weekly behaviour reports. However, inclusion of such measures proved an onerous and difficult task, with most caregivers failing to complete weekly measures. This may in part be due to the nature of work undertaken at SSU where a number of cases referred are either with caregivers, or with parents whose ability to care for their children is questionable and under scrutiny. Given these concerns the ability of parents or caregivers to monitor the behaviours of children on a weekly basis proved impossible in most cases.

### *Relationships with caregivers*

The observed discrepancy between teacher and caregiver measures, alongside information gained from the Bene-Anthony Family Relations test and the Parenting Stress Index, indicates that the relationship between the caregiver and child may have a significant impact on the effectiveness of treatment for maltreated children. It is likely that for participant one, behavioural concerns were inflated due to the placement of this child with caregivers and her distress at being separated from her family. This is supported by evidence of limited behavioural concern at school, and the changes observed when she returned to her father's care.

For some caregivers the stress of having a number of difficult and demanding children in their care may preclude them from being fully involved in treatment, thus rendering treatment less effective. The importance of the caregiver's knowledge and awareness of the child is illustrated quite clearly in the case of participant four, where an increase in symptoms was noted from pre to post treatment. Among possible explanations for this, are that rather than reflecting a worsening of symptoms post treatment, changes may be due to the caregiver becoming more aware of the child's needs and difficulties as the placement has progressed.

While there is substantial support for parental involvement in treatment programmes for children (Cohen & Mannarino, 2000; Copping et al, 2002), this is perhaps most successful where the child is living with either a parent, or with a



long term foster caregiver invested in the ongoing safety and well-being of the child. Thus, while the involvement of parents/caregivers in treatment was integral to the design of this study, reality often meant children were brought to therapy by social workers or transporters. Further, it is possible that four sessions with caregivers and informal contact and feedback are not sufficient, and that parent involvement in therapy needs to be a regular and defined aspect of each session. This would have the benefit of strengthening attachment relationships and parenting behaviour, but is more likely to prove effective when working with parents or caregivers who are likely to retain custody of the child.

### ***The Therapeutic Process***

An analysis of the therapeutic process for the children involved in the study offers tentative support for the effectiveness of the manual in helping the child to work through trauma. Through the use of the manual, children were able to address trauma in a step-wise fashion. Children appeared able to effectively use the intervention tools to talk about their trauma and the associated feelings. However, the limited change evidenced in parent and teacher report measures may indicate that treatment may have not been sufficient to effect clinical change for these children.

As suggested by Foa et al (2000), while improvement may be evident with uncomplicated PTSD in 8-16 sessions, children who have experienced prolonged victimisation, have poor premorbid adjustment, co-morbid conditions, or chronic PTSD with dissociative symptoms, may require much longer interventions. LeBlanc & Ritchie (2001) recommended 30-35 sessions as optimal for play therapy. For the children included in this study, more significant treatment gains may have been observed if treatment time had been longer.

Further given that PTSD may be a chronic waxing and waning condition in children, symptom improvement and success in achieving appropriate developmental expectations should, determine treatment length (Foa et al 2000), and treatment may be pulsed according to developmental need such as transitions, changes in living situation or further traumatic exposure (Cohen et al, 2000; James,



1989). Russ (1995) also suggested play 'modules' where specific foci are addressed at different times. Given the complex diagnostic picture of these children, it may be that such staged or pulsed intervention, may enable children to address trauma in developmentally and contextually relevant and appropriate ways. For example, modules could be developed to address attachment and safety issues with caregivers, to address trauma symptoms and behaviours, and to address other behaviours or issues such as externalising behaviour, learning needs, and social skills. Such modules could then be built upon over time, and as developmental progression enables.

The play therapy manual utilised in the present study, does lend itself to such pulsed treatment. Each of the phases of treatment could be extended to allow greater time for processing for children who have experienced multiple traumas, with additional sessions with caregivers or parents to encourage and facilitate healthy attachment relationships, and address behavioural concerns. Children involved in the present study, did appear to have difficulty with some awareness of feelings, and ability to acknowledge affect, as suggested by Trickett (1998). Further, all four children struggled with the concepts of the connection between feelings, thoughts, and behaviours. It is possible that with more sessions focused on these concepts, and the teaching of coping skills, even young children would be better equipped to cope with future difficulties and problems as they arose.

Observations of play in these children did not support the notion of repetitive or compulsive play in young children. However, this is likely to have been affected by the structured nature of the intervention, with direction aimed at working through the trauma rather than allowing the child to engage in trauma play before intervening. Children did, however, evidence a number of play behaviours consistent with maltreated children identified by White & Allers (1994) such as developmental immaturity and aggression. Three of the children also appeared to evidence the impact of maltreatment on interpersonal skills suggested by Darwish et al (2001), and reported by caregiver and teacher reports.

Three of the children also required clear limit setting and boundaries in the playroom consistent with Ryan's (1999) examination of play in maltreated

children. However, each of the children quickly formed a strong attachment to the therapist, suggesting the need for attachment and a strong and stable caregiver, as a crucial aspect of effective intervention. Some regressive behaviour was observed in both play and sand-tray work. In play, this was often seen in the ability to engage in the rules and boundaries of games commonly understood by children of 6 years and above; and in play behaviour often observed in children around four years of age, such as pouring, using copious amounts of glue and glitter, and fascination with tactile objects.

In the analysis of sand-tray work for trauma processing, children commonly engaged in burying bad feelings or the offender, and trays were often chaotic at the outset of trauma processing but became more organised as processing progressed. Both burying and chaos are reflective of trays of much younger ages (2-4 years), as outlined by Stewart (1988, as cited in Labovitz-Boik & Goodman, 2000), and perhaps reflect the age at which some of the trauma occurred and the emotional progression necessary to address the trauma. All children enjoyed making the trays, even when the trauma was difficult, and all four children 'solved' and 'resolved' their own emotional dilemma in placing the trauma in the trays by creating subsequent trays that helped them to feel safe. The sand-tray appeared to enable the children to address the trauma in safe and contained ways, without necessarily being able to verbalise all of their thoughts and feelings, but sufficient to make progress in dealing with the trauma.

### ***Strengths of the present study***

#### **The use of a play therapy manual**

The present study's main strength lies in the development and use of a play therapy manual to examine the effectiveness of play therapy with maltreated children. While no generalisations can be made due to the case study based nature of the research, as a pilot study it offers useful insights into an area much in need of empirical research. The manual in this study outlines the therapeutic process and can be replicated in more controlled conditions in order to further elucidate and inform practice in work with maltreated children using a play therapy approach.

Feedback from presentations of this study at both the Psychological Society Conference in Christchurch in September 2002, and the New Zealand College of Clinical Psychologists Conference in Auckland in October in 2002, highlighted that manuals outlining work with maltreated children, particularly those who have witnessed domestic violence are highly sought after by practitioners working in the field.

### **Bridging the Research-Practice Gap**

A further strength of the study is that this particular model of play therapy is an attempt to bridge the research practice gap, by basing a manual both in pertinent treatment literature, and clinical knowledge and creativity. The model is an adaptation of work already undertaken by a myriad of play therapists working with maltreated children, in a format allowing treatment transparency and replication.

The present study offers a tentative link between these two areas by the provision of a manual based in clinical interventions as they occur in a real world setting, with incorporation of various 'theories,' children assigned to treatment on clinical judgement of developmental age and need, and therapeutic intervention for complex cases.

By examining the usefulness of a manual based approach with clinically 'complex' cases, the present study provides a platform from which to examine the effectiveness of such methods in a real world setting, given common criticisms that psychotherapy research fails to transfer to the clinical setting.

### ***Limitations of the present study***

Limitations of the study lie in its case study based nature and the difficulty in obtaining relevant treatment sensitive measures to follow change across time. The dearth of measures relevant for this particular population of children both highlights the difficulty in working with young maltreated children from a research

perspective, and a possible reason why there is so little research available currently for practitioners.

One limitation is perhaps the lack of structured diagnostic interviews for both caregivers and children in order to provide a more comprehensive assessment of the child's clinical presentation. However, work with maltreated children, particularly those in care, is a particularly complex and difficult area. Families referred for services are often involuntary, information regarding developmental and behavioural factors may not be forthcoming from caregivers, and care-givers may have limited information of children's past or present needs and no means of measuring change. Further, care-giving arrangements frequently change with caregivers having little input into processes. Caregivers may also have responsibility for a number of maltreated children and limited resources to provide in-depth and ongoing evaluation of children's changes in behaviour.

While the inclusion of structured diagnostic interviews such as the Diagnostic Interview Schedule for Children (DISC) or the Diagnostic Interview for Children and Adolescents (DICA), may have yielded valuable information, questions remain as to the ability of parents/caregivers to adequately report symptoms of PTSD in children (e.g. AACAP, 1998). In particular, re-experiencing and avoidant behaviour, which is more reliant on the child being able to verbalise thoughts and feelings may be difficult for parents or teachers to observe. Further, children's response to, and difficulty with some of the items in the Children's PTSD Inventory would indicate that while such structured interviews are comprehensive, they may be best utilised with older children, and in younger children where caregiver's are able to provide valid and reliable data (such as having had care of the child for at least a year).

Further, while structured diagnostic interviews may yield vital information, it may prove an onerous task to undertake with a significant proportion of maltreated children. This was made evident in the present study due to the difficulty experienced by caregiver's in recording children's behaviour on the weekly behaviour record (WBR). Such in depth tracking of a child's clinical presentation for the purpose of research may be best obtained where care-givers have the care

of only one or two children, and where there is a more long-term commitment to the needs of the child.

## ***Issues and Complexities***

### **Working with maltreated children**

Therapeutic intervention with maltreated children is notoriously complex and difficult, and methodologically rigorous studies are rare (James & Mennen, 2001). Maltreated children present with a complex array of needs, with many maltreated children experiencing more than one type of abuse, having a number of behavioural difficulties, or co-morbid conditions, and they do not fit easily in categories designed for the purposes of research. As such, it can be difficult to tease apart the effectiveness and impact of treatment, from the myriad of needs and issues relevant to each case. McCloskey and Walker (2000) suggest that a diagnosis of PTSD is insufficient in itself, and that maltreated children present with a range of disorders requiring both somatic and behavioural treatment. Such findings indicate the need to customise treatment to meet the needs of individual clients.

### **Safety and stability of care**

Safety of children and issues pertaining to contextual matters are very difficult to separate from the therapy process. When working with maltreated children, ensuring safety is a paramount issue, but often involves complexities and difficulties outside of the therapist or social worker's control, such as court proceedings, custody and access arrangements, and changes in care.

While these matters can have a huge impact on the treatment of maltreated children, the provision of therapy is often imperative in order to address the most salient needs. However, time-frames for therapy and the provision of a stable long-term care-giving environment are often much longer than is ideal for these children, with many children having already been in care for a year to 18 months before therapy referrals are made. This may have a huge impact on the



effectiveness of therapy, as a number of issues and difficulties then combine in the child's clinical presentation (such as separation anxiety, grief and loss issues, attachment issues), masking, or over-riding the maltreatment/trauma presentation for which children may initially be referred.

All of the children in the present study had changes in care-giving environments during the course of therapy. These changes are likely to have impacted on their emotional and mental wellbeing, the presentation of symptoms and behaviour, and the effectiveness of the therapeutic process undertaken. This was quite vividly exemplified for participant three, who during the course of therapy showed an increase in symptoms and problematic behaviour as therapy progressed. Discussion with his caregivers revealed that at this time his mother, stepfather, and sister, had moved into the family home. Follow-up with the family post-treatment documented that his behaviour both at home and school improved as soon as the mother had moved out of the home some weeks later.

### **Attachment relationships**

Attachment issues become a significant factor in the ongoing treatment of maltreated children. In clinical practice, the ability of children to be cared for in a supportive environment where they can form strong attachment relationships has perhaps the greatest impact on therapeutic outcome. This is particularly important in working with maltreated children (Bacon & Richardson, 2001; Culbertson & Willis, 1998; Pearce & Pezzot-Pearce, 1994). For each of the children involved in therapy, separation from parents, placement with caregivers, and changes in care-giving or custody/access arrangements impacted significantly on feelings of happiness, sadness and feeling mad or scared, alongside their ability to fully engage in the therapy process.

For children where court proceedings were ongoing, the possibility of returning to parents or being placed in long term foster care was uncertain. Such change and uncertainty impacts on the child's ability to focus on the developmental tasks at hand, form attachment relationships, and succeed at school, as well as impacting on progress in therapy. Therapy undertaken with children who are 'in limbo' may

be 'holding' therapy, or the provision of an external stable attachment figure at best. For young children the formation of strong and stable attachment relationships, particularly where this is deemed inappropriate with parents, must remain paramount, and be the focus of therapy prior to embarking on working through trauma.

The impact of attachment relationships was evident when working with participant one, who, after being returned to the care of her father, reported significantly fewer unhappy feelings and worries. Attachment relationships were also evident for participant three who has been placed in the custody of his caregivers. For young children who have been maltreated, such certainty of their future care, and knowledge that they will not return to the offender, may in fact be necessary in order to proceed in their processing of trauma.

### ***Implications for clinical practice***

Implications for clinical practice resulting from this research are broad and far-reaching. While generalisations cannot be made based on such a small sample, findings tend to support concerns that play therapy has not as yet proved itself as an effective or efficacious treatment. There are numerous caveats on this, however, as the present study, being based in clinical practice as opposed to a more strictly controlled research environment, deals with complex cases that are often found in clinical practice. As such, a number of factors may mediate or moderate treatment outcome.

Key implications for practice include:

- Assessment of maltreated children needs to be multi-method in order to provide an overall picture of the child's clinical presentation and treatment needs, as opposed to based only on 'diagnosis'. However, information may be limited where children are placed outside the care of those who can offer developmental or longer-term perspectives on symptoms and behaviours.
- The need to consider time-frames relevant for children in the provision of appropriate intervention

- The need to ensure children remain in a safe and stable environment during the course of therapy in order to maximise treatment effectiveness
- The need to incorporate attachment therapy, and the involvement of parents or caregivers in treatment in order to provide a context outside of therapy where therapeutic interventions may be applied and strengthened to assist generalisation from the clinic to the home
- The need to provide 'staged' therapy, where packages of treatment are offered that enable the child to progress through therapy from the most salient issues to others (e.g. James, 1989; Gallagher et al, 1995). For example; the development of strong attachment relationships and a stable secure environment, trauma processing, and other behavioural issues and needs
- Flexibility of treatment in order to work at the child's pace, both developmentally and in terms of the child's ability to process information.

### ***Suggestions for future research***

In order to more fully examine the effectiveness of play therapy for maltreated children, replication studies are required. These may include studies using larger populations, specific populations (such as children witnessing domestic violence), and, given evidence of the possible impact of attachment relationships, use of the manual with children who have witnessed or experienced trauma, but remain in a safe and stable environment (for example single incident trauma).

Further studies could also examine the use of the manual with children older than 8, for whom there are a greater number of valid self-report measures in order to more closely examine treatment change. Other options would be the use of multiple baseline designs, either across subjects, or with the inclusion of unstructured therapy as a baseline measure prior to the introduction of the therapy manual, or a reversal design utilising these two approaches.

Subsequent to studies examining the effectiveness and generalisation of the treatment manual, comparison studies could be undertaken to examine relative effectiveness to more validated models such as CBT. Comparisons could include

CBT groups, play therapy with the use of a treatment manual, and unstructured play therapy.

In order to more fully examine the effectiveness of therapy with younger children, it is imperative that ongoing research is conducted to provide age appropriate assessment and treatment sensitive measures in order to track change following treatment. At present, work with young children is reliant on parent report. As findings discussed earlier indicate, parents and caregivers may be relatively unaware of the number of symptoms experienced by children (such as re-experiencing and avoidance), thus actual gains made in treatment may be minimised.

Given that the treatment manual designed for this study offers some level of flexibility, future use of the manual in maltreatment settings could validate and strengthen current findings and offer valuable information to clinicians working in the field of child maltreatment.

### ***Summary***

The present study sought to develop and trial the effectiveness of a play therapy manual designed for children presenting with trauma symptoms due to maltreatment. Work with maltreated children is a complex and difficult arena, with numerous confounding variables. Findings from the present study offer a glimpse into an area much in need of further research.

While the present study cannot provide evidence regarding the effectiveness of play therapy with maltreated children, examination of the therapeutic process and treatment gains made indicate that future research in this area is likely to prove beneficial. The treatment manual does appear to offer face validity to the processing of trauma in a child appropriate manner. Child self-reports also indicate reductions in symptoms.

As the present study has little material available for comparison, it must be viewed as a foray into the merging of play therapy, empirical research, and intervention

with maltreated children. Multi-method assessment provides strength to the study, but in order to determine treatment effectiveness or efficacy, more reliable and valid treatment sensitive measures are required alongside controlled and replicated studies. In order to substantiate the clinical standing that play therapy has with a large number of clinicians, a great deal of empirical research is required, the present study being only an initial step.



## Closing Summary

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In closing, the concept of building a home, and all that it entails, provides an analogy of the goals, process, and key concerns, in psychotherapy with children. The key goal of therapeutic intervention with children is to provide a safe and secure environment from which the child can heal, grow and develop. In many ways, therapeutic intervention is the building of a 'home' from which the child can safely interact with and retreat from the external world, a place of strength and refuge.

The land on which we build is much like the philosophical base we bring to our work with children. It affects the way in which we approach therapy. The scientist-practitioner model thus seeks to match the building of a home to the surrounding land or environment of the child.

Imperative to all construction is a solid foundation. The foundation of child psychotherapy needs to be built upon, and continually informed by, empirical study of effective and efficacious research. As such, the design of 'psychotherapy' becomes a fluid process; constantly changing as new information comes to hand. Fundamental to the building of a safe and stable home, is a blueprint or plan. These provide the constraints from which we work and make adjustments. Treatment manuals allow for consistent, yet flexible treatment, meet individual treatment needs, yet maintain integrity and safe, ethical practice.

The process of 'building a home' is a collaborative effort between the architect (therapist), and builder (child). As such, the quality of this relationship is imperative, with the need for trust and open communication. While the architect guides the building, and offers suggestions where changes are needed, the builder (child) is responsible for the hard work of therapy.

The child can only build with the materials (types of intervention) and skill (developmental ability), available to them, and they may be affected by a myriad of extraneous variables outside their control, which may slow or halt the building

process. Such contextual factors allow us to acknowledge that for some children, the building of a home may be phased, with parts of the building being completed as the child approaches and masters different developmental stages.

Such an analogy highlights the important role the therapist can have in the life of a child. For many children, the therapist offers the first stable and secure relationship from which they can begin to develop a sense of self and the world. As therapists, it remains our responsibility to ensure the site, the foundations, and the building plan, are the best possible for the needs of each individual child, in order to maximise their potential for development, health and wholeness of life.

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## **Appendices**

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## **Appendix A: DSM-IV criteria for Post Traumatic Stress Disorder**

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A. The person has been exposed to a traumatic event in which both of the following were present:

- (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
- (2) the person's response involved intense fear, helplessness, or horror. Note: in children, this may be expressed instead by disorganised or agitated behaviour.

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

- (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: in young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
- (2) recurrent distressing dreams of the event. Note: in children, there may be frightening dreams without recognizable content
- (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucination, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). Note: in young children, trauma-specific reenactment may occur
- (4) intense psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event
- (5) physiologic reactivity on exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

- (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
- (2) efforts to avoid activities, places, or people that arouse recollections of the trauma
- (3) inability to recall an important aspect of the trauma
- (4) markedly diminished interest or participation in significant activities
- (5) feeling of detachment or estrangement from others
- (6) restricted range of affect (eg, unable to have loving feelings)
- (7) sense of a foreshortened future (eg, does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

- (1) difficulty falling or staying asleep
- (2) irritability or outbursts of anger
- (3) difficulty concentrating
- (4) hypervigilance
- (5) exaggerated startle response

- E. Duration of disturbance (symptoms in criteria B, C, and D) is more than 1 month
- F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning

*Specify if:*

Acute: if duration of symptoms is less than 3 months

Chronic: if duration of symptoms is 3 months or more

With delayed onset: onset of symptoms at least 6 months after the stressor

\* taken from, American Psychiatric Association. 1994. Diagnostic and Statistical Manual of Mental Disorders, ed 4. Washington, APA.

## **Appendix B: Alternative PTSD criteria for children**

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A. The person has been exposed to a traumatic event in which both of the following were present:

- (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
- (2) the person's response involved intense fear, helplessness, or horror. Note: in children, this may be expressed instead by disorganised or agitated behaviour.

B. The traumatic event is persistently reexperienced in one of the following ways:

- (1) posttraumatic play: compulsively repetitive, represents part of the trauma, fails to relieve anxiety and is less elaborate and imaginative than usual play
- (2) play reenactment: represents part of the trauma but lacks the monotonous repetition and other characteristics of posttraumatic play
- (3) recurrent recollections of the traumatic event other than what is revealed in play, and which is not necessarily distressing
- (4) nightmares: may have obvious links to the trauma or be of increased frequency with unknown content
- (5) episodes with objective features of a flashback or dissociation
- (6) distress at exposure to reminders of the event

C. Numbing of responsiveness. One item needed.

- (1) constriction of play. Child may have constriction of play and still have posttraumatic play or play reenactment
- (2) socially more withdrawn
- (3) restricted range of affect
- (4) loss of acquired developmental skills, especially language regression and loss of toilet training

D. Increased arousal. One item needed.

- (1) night terrors
- (2) difficulty going to sleep which is not related to being afraid of having nightmares or fear of the dark
- (3) night-waking not related to nightmares or night terrors
- (4) decreased concentration; marked decrease in concentration or attention span compared to before the trauma
- (5) hypervigilance
- (6) exaggerated startle response

E. New fears and aggression. One item needed.

- (1) new aggression
- (2) new separation anxiety
- (3) fear of toileting alone
- (4) fear of the dark
- (5) any other new fear of things or situations not obviously related to the trauma

F. Duration of disturbance greater than 1 month

\* from Scheeringa, Zeanah, Drell, and Larrieu, 1995. Two approaches to the diagnosis of posttraumatic stress disorder in infancy and early childhood. *Journal of the American Academy of Child and Adolescent Psychiatry*, 34, 2, 191-200.

## **Appendix C: Information Sheet for Caregivers**

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### **A THERAPY OUTCOME STUDY; PLAY THERAPY WITH CHILDREN WHO HAVE EXPERIENCED THE TRAUMA OF ABUSE**

My name is Louise Woolf. I am employed as an Assistant Psychologist at Specialist Services. I am completing my Masters in Psychology at Massey University. As part of my Masters I am doing some research about how play therapy helps children who have experienced trauma through abuse. My work is supervised by Mary Dawson, Managing Psychologist at Specialist Services. My thesis supervisor is Cheryl Woolley, Senior Lecturer and Clinical Psychologist at the School of Psychology, Massey University.

The aim of this research is to evaluate a 12 week play therapy program designed to help children work through the traumatic and difficult things that have happened to them.

This is what will happen if you decide to take part in the research. If you do not wish to take part, your child will still receive therapy.

- The therapy will involve your child coming to therapy at SSU once a week for 12 weeks.
- The therapy sessions will be audio taped. The tapes will be destroyed at the end of the research process.
- There will be some sessions in these weeks with you and your child.
- You will be provided with feedback of anything you might need to know to help you care for your child.
- You will be asked to fill out some forms about your child at the beginning of therapy, at the end of the 12 weeks, and about 3 months later.

If you decide to participate in the research you have the right to:

- Choose not to participate or withdraw at any stage. Your child will still receive therapy.
- Refuse to answer questions at any time. Your child will still receive therapy.
- Ask any questions about the research and have them answered to your satisfaction.
- Discuss any aspects of the study before or during the research.
- Have access to a summary of findings when the research is completed.
- Know that all information is confidential. Your child will not be named in the research report.

As well as this it is important to know that all information collected for the purposes of assessment and therapy is subject to some confidentiality limitations. This would happen if information given indicated concerns as to the care and protection of the child. Any such information however, would in the first instance be discussed with you.

If you are interested in taking part and/or would like to ask any questions please contact Louise Woolf at Specialist Services, phone 917 5405.

## **Appendix D: Information Sheet for Children**

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### **How does play therapy help children who have had some not so nice things happen to them?**

Hi, my name is Louise Woolf. I am doing a study with Massey University and Specialist Services to see how play therapy can help children. My job is to work with children who have had not so nice things happen to them so that they can start to feel better.

Play therapy is a way for children to talk about things that have happened to them. We use puppets, drawing, playing with toys, sand, making things, reading stories and games.

I have some helpers. Fran meets with everyone at the beginning. I have two other helpers, Cheryl Woolley and Mary Dawson. They make sure I do my job properly and don't forget anything important.

If you would like to, you can help me find out about how play therapy helps you with your problems. Each week we would meet together for play therapy for 12 weeks. We will tape our talks so that nothing important you say is missed.

If you want to take part in this study you can:

- Choose to stop being in the study at any time, but still have play therapy.
- Ask me any questions at any time.
- Say you don't want to answer a question.
- Say you don't want me to write some things down.

I will let people who are looking after you know how you are doing. But I will not tell anyone things you don't want me to unless I am worried about something. If that happens, first I will talk to you, then to the person looking after you or your social worker.



## **Appendix E: Consent form for Caregivers**

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### **A THERAPY OUTCOME STUDY; PLAY THERAPY WITH CHILDREN WHO HAVE EXPERIENCED THE TRAUMA OF ABUSE**

#### ***PARENT/GUARDIAN/CAREGIVER CONSENT FORM***

I have read the Information Sheet and had the details of the study explained to me.

My questions have been answered to my satisfaction. I understand I may ask further questions at any time.

I understand I have the right to withdraw my child from the study at any time and to decline to answer any particular question. My child will still receive assessment and therapy services.

Parental/guardian consent is essential for children to participate in this study. In agreeing to participate I also provide consent for my child's participation. I understand that consent will also be sought from my child.

I agree to provide information to the researcher on the understanding that my name or my child's name will not be used without my permission.

I agree to participate in this study under the conditions set out in the Information Sheet.

***Signed***.....

***Name***.....

***Date***.....

## Appendix F: Consent form for Children

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### **How does play therapy help children who have had some not so nice things happen to them?**

Louise has told me what will happen. She has answered my questions. I can ask more questions later if I need to. Louise has told me that:

- I can stop doing the study at any time if I want to.
- If I don't want to answer some questions that is okay.
- If I don't want to do the study any more, or don't want to answer questions, I will still be able to have play therapy.
- What I talk about is private.
- Some things might need to be talked about with the people who look after me, or my social worker. If that needs to happen, Louise will talk to me first.

I would like to do this

.....

I would not like to do this

.....

**Appendix G: Weekly Checklist for Children**

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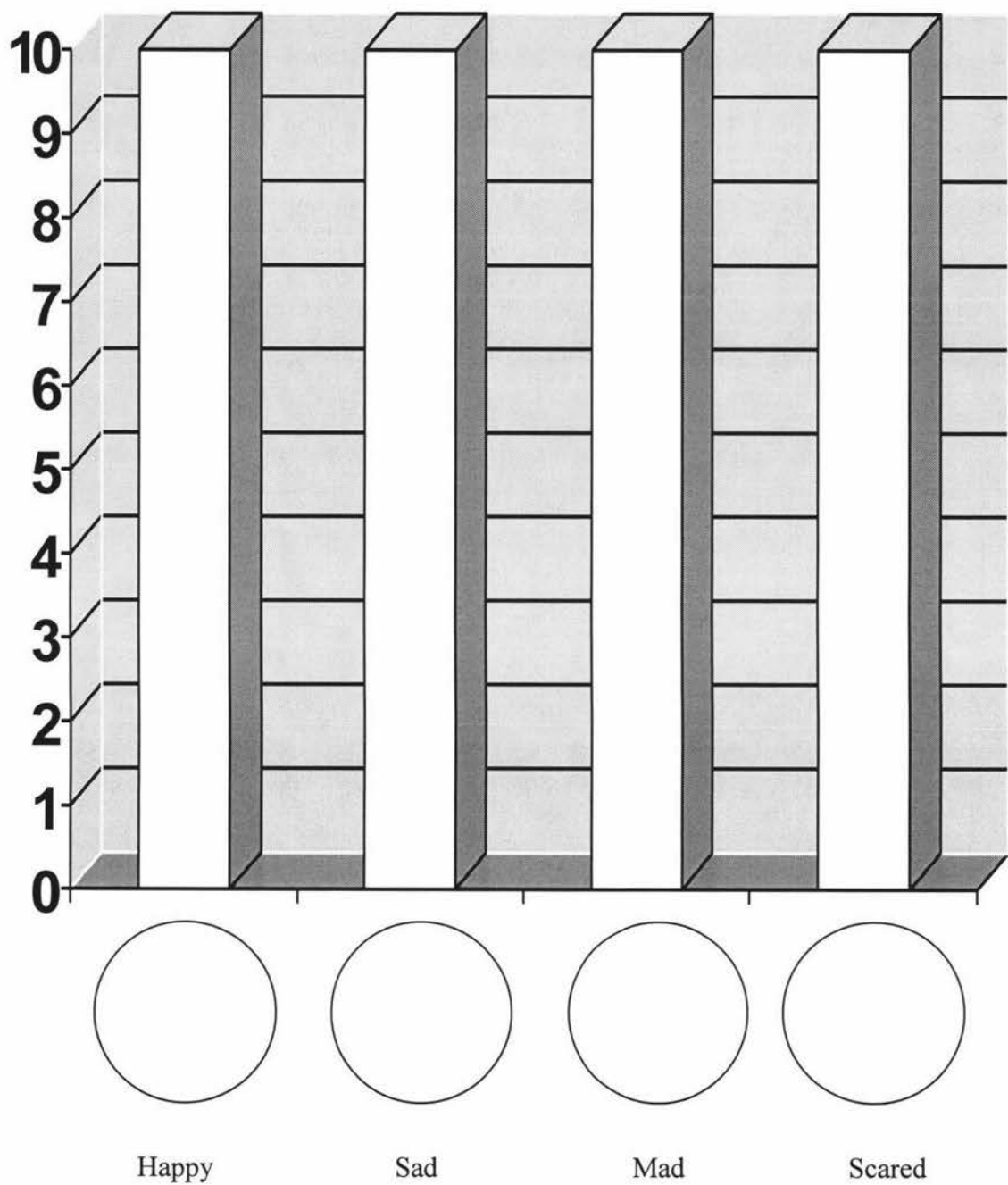
Name: \_\_\_\_\_ Date: \_\_\_\_\_

For the 3 things you want to change, tick in the box which shows how much each one has been a problem for you in the last week.

Problem	None of the time	Some of the time	Most of the time	All of the time
1.				
2.				
3.				
4.				

**Appendix H: Feelings Chart**

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## Appendix I: Weekly Behaviour Report for Caregivers

Name: \_\_\_\_\_ Date: \_\_\_\_\_

*Parent/Caregiver:* Each time your child has any of the following behaviours this week, please tick the box indicating what day that behaviour occurred.

Behaviours	Mon	Tue	Wed	Thur	Fri	Sat	Sun
1. Took more than 30 minutes to fall asleep at bedtime.							
2. Refused or resisted going to sleep in own bed.							
3. Woke up in the middle of the night.							
4. Had nightmares or bad dreams.							
5. Cried at bedtime.							
6. Refused to separate from you.							
7. Cried when you left him/her with babysitter or another family member.							
8. Refused to leave the house or go to school.							
9. Clinging to you during the day.							
10. Afraid of things or situations that didn't used to scare him/her (i.e. new fears)							
11. Physical fighting, getting into fights, being aggressive.							
12. Temper tantrums.							
13. Angry outbursts, irritable or easily frustrated.							
14. Difficulty concentrating, listening or paying attention.							
15. Jumpy or nervous around loud noises, or being watchful.							
16. Playing out, drawing or talking about what happened over and over again.							
17. Not enjoying activities or friends used to enjoy.							
18. Not showing any emotions.							
19. Seeming to 'space out' or daydream.							
20. Difficulty remembering things (new and old skills).							

21. Returning to behaviour had outgrown (i.e. bedwetting, drinking from bottle, sucking thumb etc).							
22. Becoming upset when reminded about what happened.							
23. Complaining of stomachaches, headaches, feeling dizzy or difficulty breathing.							