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The Use of Play Therapy with Adult Survivors of Childhood Abuse

Mary J. Roehrig
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THE USE OF PLAY THERAPY WITH ADULT SURVIVORS
OF CHILDHOOD ABUSE

A Dissertation
Presented in Partial Fulfillment
of the Requirements for the Degree
Doctor of Philosophy

by
Mary J. Roehrig
April 2007
THE USE OF PLAY THERAPY WITH ADULT SURVIVORS OF CHILDHOOD ABUSE

A dissertation presented in partial fulfillment of the requirements for the degree Doctor of Philosophy

by

Mary J. Roehrig

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April 19, 2007

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ABSTRACT

THE USE OF PLAY THERAPY WITH ADULT SURVIVORS OF CHILDHOOD ABUSE

by

Mary J. Roehrig

Chair: Nancy J. Carbonell
ABSTRACT OF GRADUATE STUDENT RESEARCH

Dissertation

Andrews University
School of Education

Title: THE USE OF PLAY THERAPY WITH ADULT SURVIVORS OF CHILDHOOD ABUSE

Name of researcher: Mary J. Roehrig

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Date completed: April 2007

Problem

A growing trend among therapists is the use of play therapy interventions with adult clients to facilitate resolution of early childhood trauma and to promote emotional and spiritual growth. The purpose of this study was to explore the use and effectiveness of play therapy techniques with adult survivors of childhood abuse.

Method

In an exploratory approach, therapists were invited to participate in an online survey. Of the participating therapists, 21 agreed to a subsequent in-depth interview. The Theme Analysis for Word-Rich Data was used to identify themes from the interviews.
Results

Play therapy with adult survivors of childhood abuse was used by 64.9% of the participating therapists in this study. Common techniques used in treating adult survivors were: (a) journaling, (b) sand tray, (c) art, (d) anger management, (e) imagery, (f) role play, and (g) humor. A categorization according to intent or goal of therapy was noted. When the intent was to express feelings, the art and sandplay techniques predominated. When the purpose was to manage anger, more physical activities were suggested.

Therapists were asked to rate the effectiveness of play therapy with adult survivors. On a 5-point Likert scale, with 5 = Very effective and 1 = Ineffective, 81% of the participants selected either a 4 or 5, with the mode and median both being 5 = Very effective.

In a process called Theme Analysis for Word-Rich Data, six themes emerged from analysis of the qualitative interviews. These were: (a) non-threatening, therapeutic environment, (b) therapist characteristics, (c) successful techniques, (d) developmental perspective, (e) justification for using play therapy, and (f) spirituality. These six themes became the building blocks for the proposed therapy model presented in this study.

Conclusions

Results from this study suggest that play therapy is an effective approach in treating adult survivors. Further exploration is needed to formalize this approach and to empirically test its effectiveness. A conceptual model for practice is presented within this study to include (a) suggestions for therapist academic and practicum preparation; (b) suggested techniques; and (c) guidelines for theory development.
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<tr>
<td>CSA</td>
<td>Childhood Sexual Abuse</td>
</tr>
<tr>
<td>DID</td>
<td>Dissociative Identity Disorder</td>
</tr>
<tr>
<td>EMDR</td>
<td>Eye Movement Desensitization and Reprocessing</td>
</tr>
<tr>
<td>PTSD</td>
<td>Posttraumatic Stress Disorder</td>
</tr>
<tr>
<td>RAINN</td>
<td>Rape, Abuse and Neglect National Network</td>
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CHAPTER 1

INTRODUCTION

The number of reported cases of child sexual abuse (CSA) increased 322% over the decade between 1980 and 1990 (Sorensen & Snow, 1991). In 1996, the United States Department of Health and Human Services reported an increase in known cases from 1.4 million in 1986 to over 2.8 million in 1993, twice the number of cases being reported in a 7-year period. Interestingly, a decline was noted by the United States Department of Health and Human Services (2001) from over 900,000 cases in 1998 to an estimated 826,000 in 1999 and they believe this decrease might be attributed to an increase in child abuse and neglect awareness. The Rape, Abuse and Incest National Network (RAINN) reports a 69% decrease in rape since 1993 (2007). Nevertheless, these are alarming statistics. It is even more frightening to contemplate the number of victims who do not report childhood sexual abuse out of shame, fear, confusion, and/or inability to do so.

Studies of adult survivors have been largely atheoretical to this point, focusing on characteristics of survivors and the incidence of childhood sexual abuse in select clinical groups (Cole & Putnam, 1992). The long-term effects of physical, sexual, and emotional abuse in childhood have been well documented (Gil, 1988; Herman, 1992; Stean, 1988). These long-term effects include fear, anxiety, depression, anger, hostility, inappropriate sexual behavior, poor self-esteem, tendency toward substance abuse, and difficulty with interpersonal relationships (Browne & Finkelhor, 1986).
Major depression is commonly reported by adult survivors of childhood sexual abuse (Beck, 1967, 1987; Bifulco, Brown, & Adler, 1991; Bondewyn & Liem, 1995; Brown & Harris, 1978; Burnam et al., 1988; Duman, Heninger, & Nestler, 1997; Kendler, Kessler, Neale, Heath, & Eaves, 1993; Mazure, 1998; McCauley et al., 1997; Mennen & Meadow, 1994; Post, 1992; Raison & Miller, 2003; Shrout et al., 1989). Weiss, Longhurst, and Mazure (1999) reviewed empirical data linking childhood sexual abuse to the development of depression in adulthood. They concluded that childhood sexual abuse may predispose persons to depression in adulthood due to changes in the regulation of the hypothalamic-pituitary-adrenal (HPA) axis. A study by Levitan et al. (1998) reported similar findings linking childhood sexual abuse with major depression in adulthood. Childhood sexual abuse is associated with a dysfunctional home environment, which, in turn, may be associated with a higher incidence of depression in adulthood (Gladstone, Parker, Wilhelm, Mitchell, & Austin, 1999).

Around the turn of the century, psychiatry observed a relationship between dissociative process and traumatic childhood experience (Coons, Bowman, & Milstein, 1988; Kluft, 1985; Putnam et al., 1996; Ross, 1997; van der Kolk, 1988; Wilbur, 1984). Many studies support this link between childhood traumatic experiences and proneness to dissociation (Chu & Dill, 1990; Chu, Frey, Ganzel, & Matthews, 1999; DiTomasso & Routh, 1993; Horen, Leichner, & Lawson, 1995; Irwin, 1995; Kirby, Chu, & Dill, 1993; Saxe et al., 1993; van der Kolk & van der Hart, 1989; Zlotnick et al., 1995). In a review of the criminal records of 11 men and one woman with the diagnosis of Dissociative Identity Disorder (DID), Lewis, Yeager, Swica, Pincus, and Lewis (1997) noted a history of early severe abuse.
Physical health problems in adulthood have been associated with childhood physical and sexual abuse. Sachs-Erickson, Blazer, Plant, and Arnow (2005) looked at a community sample of 5,877 adults who had serious medical problems. They found that those who had been physically abused as children developed a serious physical illness twice the rate of those who had not been physically abused. Those who had been sexually abused as children developed a serious physical problem nearly one and a half times more frequently than those who had not been sexually abused. Headaches (Golding, 1999), diabetes, arthritis, gynecological problems, breast cancer in women (Golding, 1994), and obesity (Williamson, Thompson, Anda, Dietz, & Felitti, 2002) are more common in individuals who have experienced sexual abuse. Romans, Belaise, Martin, Morris, and Raffi (2002) found chronic fatigue syndrome, asthma, and heart problems to be associated with childhood sexual abuse.

The adult survivor of childhood abuse may lack self-confidence; lose the ability to feel good about self; experience a loss of hope, freedom, and dignity; develop physical and mental health problems; experience a loss in the ability to trust; and be unable to relax and enjoy life. Attempts to deal with the past often involve ineffective coping mechanisms such as alcohol and drug abuse, obsessive behaviors and strict routines, self-harming (e.g., cutting, scratching, or burning), and/or breaking ties with the abuser and others. Many adult survivors keep the secret of their abuse hidden out of shame, guilt, and embarrassment.

Most adult survivors of childhood abuse who present for therapy do so with fear, apprehension, shame, and mistrust. As a survival strategy, they seek order and consistency in their lives. Repression is commonly found as a defense for coping with
childhood trauma. It is often very difficult for these clients to re-enter the painful past in order to resolve past conflicts, forgive themselves, and make peace with their past (Simonds, 1994).

Traditional treatment for adult survivors of childhood abuse has been geared to the expected developmental level of adulthood, even though these clients did not sustain the trauma as adults, but rather during an earlier stage in their cognitive development. According to Piaget and Inhelder (1969), a child goes through four stages in the process of being able to logically reason and think abstractly. They emphasized that movement through these stages depended on biological, intrapersonal, and interpersonal factors. It seems likely that an adult who was traumatized in an early stage of cognitive development would respond to past memories of abuse with much of the same thinking style as he or she did at the time of abuse.

Play therapy is a well-established strategy for assessing and counseling children (Axline, 1947, 1969; Brown & Prout, 1989; Kratochwill & Morris, 1991; McMahon, 1992; O'Connor, 1991). Within the safe confines of play, a difficult or traumatic experience may be re-experienced and the outcome changed. Erikson (1963) noted that young children learn to master their environments through the use of play. The question was thus asked: Is the use of play therapy a viable and effective modality for use with adult survivors of childhood abuse?

**Statement of the Problem**

Serious mental and physical health problems may develop in the adult survivor of childhood abuse. At the very core of interpersonal relationships is the ability to trust. For the adult survivor, the ability to trust is lost. To cope with a painful past, many
survivors turn to alcohol, drugs, obsessive thinking and compulsive behaviors, self-harm, and repeated entry into dysfunctional relationships. Play therapy with adult survivors of childhood abuse has become a frequent topic discussed among play therapists at statewide and national conventions in play therapy. Clinical wisdom believes it to be a wonderful therapeutic intervention to help adults resolve the disruptions of their childhood years caused by childhood abuse. Yet, few studies have actually looked at how many use this technique, what it consist of, and whether it is effective or not. More studies are needed in this area.

**Purpose of the Study**

Play therapy is used extensively with sexually abused children. Some therapists, however, have informally reported using play therapy techniques with adult survivors of childhood abuse. Play therapy stimulates a release from defenses, leading to a safer exploration of self. It may turn out to be an effective approach in working with adult survivors of childhood abuse. The primary purpose of this study was to explore the use and effectiveness of play therapy techniques with adult survivors of childhood abuse. This study looked at current approaches used with adult survivors of childhood abuse, the use of play therapy with adult survivors, the extent of that use, and therapist evaluation of outcome when using play therapy techniques with adult clients.

**Research Questions**

In this study, the following questions were asked:

1. To what extent is play therapy used by therapists who work with adult survivors of childhood sexual abuse?
2. What techniques are commonly used by therapists who work with adult survivors of childhood sexual abuse?

3. How do therapists who use play therapy with adult survivors of childhood sexual abuse rate the effectiveness of play therapy techniques?

**Significance of the Study**

Trauma from childhood abuse affects the adult survivor's mental health and relationships (Browne & Finkelhor, 1986; Simonds, 1994). The ability to trust sets the stage for personality development. Autonomy and initiative are subsequent stages in the healthy development of personality (Erikson, 1963). When these stages are obstructed, as in child abuse, a faulty personality results. Intimacy is driven by a need for protection and caring, but becomes compromised by the fear of abandonment and exploitation.

Survivors of childhood abuse often lack the skills to resolve interpersonal conflict, leading to unstable relationships and further victimization (Herman, 1992). The adult survivor often learns to construct a strong defensive fortress. Traditional adult therapy approaches may fail in breaking through the fortress to reach the frightened child within the adult client. At a time when cost-effective treatment is mandated, studies investigating effective treatment for adult survivors of childhood abuse are essential. Because the adult survivor's early childhood was scarred by trauma, play therapy (used extensively with children who have been sexually abused) has the potential to facilitate early resolution and safe reconstruction of a healthy paradigm of self in the adult client. It is imperative that effective treatment: (a) provides the client with a mechanism to resolve the effects of early trauma; (b) leads to the client's increased self-esteem; (c) teaches effective coping skills; and (d) teaches relationship building.
skills. This study hopes to discover play therapy to be an effective treatment approach for adult survivors.

**Theoretical Framework**

Huizinga (1949) viewed play as basic to human existence. Play is spontaneous and freeing. It allows the child to control his or her environment. Play therapy is rooted in the psychoanalytical theory of Sigmund Freud (1905, 1909), Anna Freud (1928, 1965), Melanie Klein (1932), and Jung (1964), the work of Virginia Axline (1947, 1969) and cognitive-behavioral theory (Knell, 1993, 1994, 1997, 1998). O'Connor and Braverman (1997) identified 13 models of play therapy. However, according to O'Connor (2000), not all of these models are well developed. A discussion of those aspects of psychoanalytical theory, Axline's humanistic approach, and cognitive-behavioral theory that provided the framework for this study follows.

**Psychoanalytical Theory**

Sigmund Freud (1905) proposed a model of personality development that included movement through psychosexual stages. He viewed the personality as having three components: the id, ego, and superego. Their combined purpose was to maintain the integrity of the developing personality. Since later interpersonal functioning was believed to be dependent on successful integration of the tripartite structure as it moved through these stages, trauma and/or conflict occurring at any or all of the stages would most likely lead to serious pathology, at worst, and difficulty in interpersonal relationships, at the very least. Melanie Klein (1932) postulated that the toddler developed a primitive superego based on perceptions of the primary caretaker. The image of the caretaker has both nurturing and punitive qualities. These images are present.
even when the caretaker is not. Thus, the punitive aspect of the superego would provide the child with his or her own punishment in the absence of the caretaker.

Through the use of interpretation, the psychoanalytical therapist assists the client in vision of the psychic structures, leading to optimal development (O’Connor, Lee, & Schaefer, 1983). This is accomplished by gradually working through intrapsychic issues. By becoming aware of unconscious conflicts, the client can resolve these issues and move on to the next level of development. Behavioral change occurs following insight and the process of working through (elaborating and expanding) the issues. The key component of psychoanalytical theory that is applicable to use with adult survivors is the emphasis on events and relationships that occurred during development of the personality.

Klein (as cited in Esman, 1983) believed that the child’s play was equivalent to free association in psychoanalysis of the adult client. Play provided a source of clinical data as well as a mechanism for engaging the child.

Anna Freud (1974) used play as a mechanism for establishing a therapeutic alliance, especially with a resistant-child client. Familiar toys were utilized to promote trust and dependency on the therapist. Freud’s use of magic tricks was especially appealing (O’Connor, 2000). After establishing a therapeutic relationship, Freud shifted to the analysis of dreams and daydreams in her child clients. Like Jung (1964), she found dream analysis to be a source of insightful information. She discovered that children were able to create mental images of their fantasies and were subsequently able to verbalize feelings related to these images (O’Connor, 2000).

The use of play in therapy allows the client to alter situations/problems, so that
change is a realistic outcome (Watzlawick, Weakland, & Fisch, 1974). Play therapy offers the client the opportunity to see things differently, that is, to reframe problems in a more positive light (Levy, 1987). According to Gladding (1993), play therapy strategies can be used throughout the lifespan. Gladding explains the basis for play therapy in counseling is in Freudian, Jungian, and Rogerian theories (Gladding, 1993, p. 107). The client can express him or herself in a safe environment, without fear of real consequences. When play therapy is used with adults, the client is afforded a ‘space’ away or oasis from life’s problems. He or she can then draw upon resources to reclaim control of their life. This is particularly important since a sexually abused child often enters adulthood with this awful secret. Trauma in childhood disrupts the usual developmental path. It seems only logical that resolution of early trauma be facilitated by visiting, via play therapy, the traumatic past. Within the safe confines of supportive therapy, resolution and further growth might occur.

The Work of Virginia Axline

Axline (1947) developed a play therapy technique based on the belief that children inherently strive for growth. This natural desire is subverted in the child who is emotionally disturbed. Environmental toxicity is seen as the cause of pathology. Experience has taught the child that he or she is wrong. The child compensates by adopting the values of others, which leads to internal conflict. The child’s self-esteem and self-acceptance are poor. The goal in play therapy is to allow the child to become more self-actualized. By creating, in play therapy sessions, an optimal environment, the child’s self-esteem may be enhanced. This, in turn, causes positive behavioral change. The therapist’s role is to create an atmosphere where this can occur. Empathetic
responding, limit setting, information giving that leads to growth, and continual interaction, either verbally or through play, are essential characteristics of this approach. Paramount to the therapeutic relationship is a safe environment, where the client is accepted and encouraged to express emotions. In this environment, a client may experience a sense of control and confidence in decision-making.

The relationship developed between the client and the therapist, insight, and freeing of the client’s drive toward self-actualization are seen as the curative elements of Axline’s play therapy. Change is based on emotions rather than on cognitive processes (Shirk & Russell, 1996). Axline’s play therapy technique most likely would be pertinent to adult clients who have suffered silently since childhood. The warm, accepting atmosphere created by the therapist is essential for growth to take place. For the adult survivor, this may be the first time to feel accepted and nurtured. It may very well be the first time that the client feels good about herself/himself. The permissive atmosphere used by the play therapist may be imperative in allowing resolution of childhood trauma.

Cognitive Behavioral Theory

The interaction of thought, emotion, behavior, physiology, and environment comprises the elements of cognitive behavioral theory (Beck, 1967, 1972; Beck & Emery, 1985). According to Knell (1997), language has a significant effect on behavior. In contrast to the psychoanalytical proposition that pathology is caused by a disruption in internal processes or the humanistic belief that a faulty environment is to blame, the behavioral concept of pathological development suggests abnormal patterns of reinforcement. The cognitive behavioral position is that irrational thoughts generate disturbances in emotions and behavior. A person’s beliefs and assumptions, in turn,
shape his/her perceptions and interpretation of events. Thus, illogical or distorted
cognition is the source of psychological problems (Beck, 1976; Knell, 1997).

A connection is made between the child’s interpersonal schema (a template for
understanding interpersonal interactions) and the child’s social and emotional problems.
The schema that develops with the primary caregiver is most important.

The goals in cognitive behavioral play therapy are to assist the client in discovering
and correcting the faulty interpersonal schema and in learning effective cognitive/verbal
mediation strategies (O’Connor, 2000). For many adult survivors of childhood abuse,
negative, self-derogatory thinking and repeat patterns of inappropriate behavior have
become a learned way of life. By returning, via play therapy, to early conflicts and
abuse, it is hoped that the adult survivors will be able to restructure their past, gaining
control of their future.

**Definition of Terms**

In this study, the following terms are defined, as presented here.

**Adlerian Therapy**: Rooted in psychotherapy, education, and anthropology,
*Individual Psychology* views human nature as being socially based. The individual’s
perception of events shapes the personality. The goal of therapy is to assist the client in
becoming more fully functioning (Fortinash & Holoday-Worret, 2000).

**Adult Survivor**: An adult survivor is one who has experienced physical, emotional,
verbal, and/or sexual abuse and neglect during childhood.

**Art Therapy**: Feelings and experiences are expressed in a non-verbal manner
through a variety of media. It may include, but is not limited to, drawing, painting, and
creating images in clay, sand, ceramics, paper, or other three-dimensional substances. The use of colors and different textures contributes to the expression (Malchiodi, 2005).

**Attachment theory (Bowlby):** The relationship between infant and caregiver, which gives rise to adaptation as the infant experiences biological and emotional needs. This early relationship affects the infant’s emerging concept of self and provides a pattern for interactions with others (Antai-Otong, 2003).

**Behavioral Theory:** Assumes that all behavior is learned. Behavioral therapy assumes this basic premise in that undesired behavior can be changed through a process of reinforcement. Operant or desired behaviors generally receive a positive reinforcement. Negative reinforcement may also be used to distinguish the undesired behavior. Operant conditioning occurs when the stimulus is no longer required to elicit the desired behavior.

**Cognitive Theory:** Mental processes involved in thinking, knowing, remembering, planning, and perceiving are basic elements of cognition. Schemata, which are patterns or structures of a person’s beliefs, values, and assumptions, assist in shaping personality (Antai-Otong, 2003).

**Cognitive Therapy:** Based on the premise that illogical or distorted perceptions of events and/or people cause problems, therapy challenges these irrational beliefs, faulty reasoning, and negative self-statements (Antai-Otong, 2003; Beck, 1995).

**Cognitive Theory of Developmental Stages (Piaget):** Based on the relationship between thought and action, distinct stages occur in a child’s development, reflecting characteristic thought and subsequent action (Inhelder & Piaget, 1958).

**Cognitive Behavioral Therapy:** An empirically based, goal-oriented approach that
involves active and collaborative efforts on both the therapist’s and client’s behalf. The
therapist assesses the client’s behavior, as well as thoughts and feelings. Together, the
therapist and client develop a plan to apply newly learned skills to everyday life (Stuart &
Laraia, 2005).

**Directive Play Therapy:** The therapist provides direction in the session, including
selection and/or choice of toy or activity. Sessions are goal-directed and pre-planned.
The therapist may actively expose the client to the trauma (Schaefer & Cangelosi, 1993).

**Eclectic approach:** A variety of theories and strategies may be utilized in therapy
to best treat the client.

**Experiential:** The expression of feelings, emotions, and thoughts through creative
arts and activities that utilize symbolism to communicate their meaning. Included are
dance, movement therapy, art, and role playing (Felber, 2001).

**Expressive Therapy:** Therapeutic use of arts and play, used to facilitate change,
problem solving, communication, and interpersonal skills. Clients are encouraged to
engage in the process of self-expression with the purpose of communicating feelings,
emotions, perceptions, and experiences. Art, music, dance, drama, poetry, play, and
sandtray are examples of expressive therapy (Malchiodi, 2005).

**Filial Therapy:** Designed to help children and families overcome problems and
strengthen family relationships, parents are taught to conduct expressive play sessions
with their children (Guerney, 1964; VanFleet, 1994).

**Gestalt Theory:** Human beings are viewed as open systems, actively interacting
with their environment. Emphasis is on the here and now. An expressive therapy,
feelings are stressed (Fortinash & Holoday-Worret, 2000).
Humanistic Psychology: Behavior is motivated by the desire to self-actualize, to preserve, and enhance the self. The goal in therapy is to move the client toward openness and growth (Fortinash & Holoday-Worret, 2000).

Kohlberg's Stages of Moral Development: Based on Piaget and John Dewey, Kohlberg believed that people progressed through stages in their moral development. These stages are the basis for ethical thinking and subsequent behavior (Barger, 2000).

Interpersonal Social Theory (Sullivan): Focusing on interpersonal relationships, a person develops through a series of stages. The self-system called personification includes attitudes and feelings about oneself and others. A positive self-concept develops through positive interpersonal relationships. In turn, communication is the focus of the therapeutic relationship (Antai-Otong, 2003).

Non-directive Play Therapy: This approach is based on the assumption that the client has the ability to solve his or her own problems and grow (mature) from the experience. Principles include: (a) warm therapeutic relationship; (b) acceptance of the client as he or she is, (c) feeling of permissiveness in the relationship, (d) reflection of client’s feelings, (e) respect for client’s ability to solve problems, with an opportunity to do so, (f) client led, (g) gradual process, and (h) limitations necessary to maintain reality and client awareness of his or her responsibility in relationship (Axline, 1947).

Object-relations Theory (Mahler): An object is a person or a part of a person that the infant associates with interpersonal pleasure. The infant has a symbiotic relationship with the object and must experience separation in order to attain individuation (McIntyre, 1999).

Play: A pleasurable, spontaneous (Beach, 1945; Hughes, 1995; Plant, 1979;
intrinsically complete activity in which a person freely engages. In childhood, play is usually person-oriented (O’Connor, 1991) rather than being directed by a goal or outcome. Play does not depend on external rewards or influence of others (Csikszentmihalyi, 1976; Plant, 1979).

**Play therapy:** A systematic approach using elements of play to establish an interpersonal process, whereby a therapist assists a client in resolving psychosocial difficulties and achieving optimal growth (Association for Play Therapy, 1997; O’Connor, 2000).

**Play Therapy Techniques:** Elements of play, which include, but are not limited to, art, puppets, sand, drama, water play, dolls, costumes, and games (Schaefer & Cangelosi, 1993). These techniques are used to assess as well as treat clients who have difficulty expressing feelings, emotions, and experiences verbally.

**Prescriptive Treatment:** A customized treatment approach, designed for the specific client, which may use a variety of interventions (Norcross, 1993).

**Psychoanalytical Theory:** A theory of personality development, which suggests that individuals are driven by impulses and the personality, is organized to control the impulses to the person’s best interest. There are two levels of consciousness: (a) conscious and (b) unconscious, which is further divided into the preconscious and unconscious proper. The personality is structured into three parts: (a) id, (b) ego, and (c) superego. Sigmund Freud (1905) further proposed psychosexual stages of development (Fortinash & Holoday-Worret, 2000).

**Psychodrama:** Individuals and/or groups are able to act out conflicts, relationship issues, and problems, as well as express experiences and feelings, which they could not
otherwise verbalize. Peers and/or the therapist provide assistance in expressing of feelings and experiences and in resolving conflicts (Malchiodi, 2005; Moreno, 1946).

**Psychosocial Development (Erikson):** Erik Erikson (1963) proposed a theory of personality development that continued throughout the life span. At each stage, tasks must be mastered in order to successfully progress to the next stage. Success at each stage helps to strengthen the ego. Failure to resolve conflict in a given stage leads to maladaptation or mental illness.

**Self-Relations Therapy (Gilligan):** The client is taught to relate to his unconscious in a personal way through hypnosis, but learns to stay in the here and now, rather than the past (Gilligan, 1997).

**Systems Theory/Family Systems Theory:** In this view, individuals, families, and groups are living, open systems, interacting within themselves, with their environment and with others. A change in one part of the system affects the entire system. Growth, change, and learning occur through interaction within, among, and between systems (Antai-Otong, 2003).

**Trauma Model:** With roots in cognitive behavioral theory, techniques and strategies are directed toward recovery and growth. Emphasis is placed on cognitive restructuring, as the client learns to perceive a more meaningful life and realize a more positive self-concept (Ross, 2000).

**Delimitations**

In this study, therapists who work with adult survivors of childhood abuse and who use play therapy in treating their clients were sought. Thus, four sources were utilized in seeking experienced therapists who met the criteria. One source was the
Directory for the Association for Play Therapy (Association for Play Therapy, 2003). Play therapist supervisors were contacted, as the assumption for this choice was that since they were certified in play therapy, they would be potentially favorable to using play therapy techniques with adult clients. A second source was the Psychology Today's Therapy Directory (2003). Therapists who identified sexual abuse as an area of interest/expertise were selected as potential participants. The third source was recommendations from the Director of a Trauma program that utilizes play therapy techniques with adult survivors. The final source was recommendations made by a local university Counseling Center director. Self-identification of therapists that they had experience in using play therapy techniques with adult survivors from these four sources served to delineate the participant pool.

Limitations

Because play therapy is primarily used with children, therapists may choose to use other approaches in working with adult clients. It is impossible to reach every therapist who works with adult clients; therefore, the number of therapists who actually do use play therapy techniques with adult survivors of childhood abuse is unknown. This could limit the generalizability of the results.

Organization of the Dissertation

This study is organized into five chapters. Chapter 1 serves as an introduction and contains the problem statement, purpose, research questions, significance, theoretical framework, definition of terms, and limitations of the study. Chapter 2 contains a review of the literature. The methodology is presented in chapter 3, including the design, sample
selection, data collection methods, and data analysis. Results are discussed in chapter 4.

Finally, conclusions based on the results and recommendations for further study are presented in chapter 5.

Summary of Chapter 1

Chapter 1 introduced the multiple issues that adult survivors of childhood abuse face. Because of a tendency to hide, forget, or cover up the childhood abuse, adult survivors frequently present for help with physical and other mental/emotional problems. That makes the task of treatment complicated and often misdirected.

Play therapy is an established treatment modality for children who have been abused. This study explored the application of play therapy to treatment of adult survivors.
Play therapy with adult survivors of childhood sexual abuse is an evolving area. In casual conversations with therapists, many have reported using play therapy techniques with adult survivors of childhood sexual abuse, but there is little in the literature on the extent of its use, the specific techniques used, or the effectiveness of using play therapy techniques with adult clients. Research on play therapy with adult survivors of childhood sexual abuse is sparse. Thus, the focus of this study is timely.

In order to provide a framework for studying play therapy with adult clients who have been sexually abused as children, the literature review addresses the following: what is known regarding the use of play therapy with children who have been sexually abused; the long-term effects of sexual abuse on the victim; current strategies that are used in treating adult survivors of childhood sexual abuse; and related research. First, a historical perspective and overview on play therapy is presented. Following this is a discussion of the long-term effects of sexual abuse on the victim. Next, current treatment modalities for working with adult survivors of childhood sexual abuse are presented. Finally, a discussion of related research ensues.

**Play Therapy With Children**

**Historical Perspective**

Sigmund Freud (1909) is credited with being the first person to do psychotherapy
with children. He attempted to relieve the phobic fears of Little Hans by directing Hans's father in techniques aimed at conflict and fear resolution. Freud saw play as a tool for understanding children and a way to help them gain mastery over psychological trauma. Around the same time as Freud, the Austrian psychiatrist Hug-Hellmuth (1921) began to use play in therapy with children. Initially, she observed and played with children in their home in order to familiarize herself with the child's daily environment. She holds the distinction of being the first clinician to use observations of play as a method for treating children with psychological difficulties (Schaefer & Cangelosi, 1993).

Building on the work of her father and Hug-Hellmuth, Anna Freud (1928) used play as a mechanism for engaging child clients in therapy, especially those who were resistant to therapy. She used favorite toys, games, and magic tricks as a means of creating a therapeutic alliance. Once this relationship was established, she slowly changed her emphasis to more verbal activity. Rather than using the traditional psychoanalytical technique of free association with the child client, she utilized dream and daydream analysis. She found that the children were able to create mental images of their fantasies and, subsequently, verbalize them.

Melanie Klein (1932) believed play was a substitution for verbalizations. She felt that children's verbal skills were not developed enough to express complex thoughts and feelings. Klein viewed play in the child client as equivalent to free association in psychoanalysis of the adult client. Whereas Anna Freud used play to create a therapeutic alliance, Klein spent little time on introductory work, entering quickly into the task of interpreting the child's play behavior. Another major difference between the two is in the type of client chosen for play therapy. Freud primarily focused on children with anxiety-
based neuroses. Klein, however, believed any child, either normal or vastly disturbed, could benefit from play analysis (O'Conner, 1991).

Eighteen years after Hug-Hellmuth's introduction of play therapy, Levy (1938) developed what he called Release Therapy. This form of structured play therapy was used to assist traumatized children. Based on Sigmund Freud's concept of the repetition compulsion, Levy provided a supportive environment where the child could "replay" traumatic events. The therapist, being aware of the child's specific difficulty, arranged dolls and play objects in a manner that would promote catharsis and insight through symbolic play. The client could then restructure blocked areas of development. Central to Levy's approach and psychoanalytical therapists, in general, are: (a) the use of a psychoanalytical framework; (b) a belief in the cathartic value of play; and (c) the active role of the therapist in determining the focus and course of treatment (O'Conner, 1991).

Solomon (1938) simultaneously developed a technique for dealing with impulsive and/or acting-out children known as "active play therapy." Through play, the child could express rage and fear without fear of reprisal. The therapist guides the child in a redirection of energy and time. Past traumatic experiences are separated from future consequences and present reality.

In 1947, Virginia Axline authored her now classic book, *Play Therapy*, in which she put forth guidelines for conducting play therapy. (A discussion of these guidelines is contained in the section following this one.) Her humanistic approach in play therapy is based on the philosophy that each individual strives to become the best that he or she can be. According to Axlinian tenets, it is the environment that is to blame for the child's inability to progress towards self-actualization. The role of the therapist is to provide a
therapeutic atmosphere in which the child’s own self-actualizing tendencies may flourish. After creating this facilitative environment, the Axlinian therapist then assists the child in verbally processing the experiences to optimize generalizations. In some cases, this means leading the sessions and, in some, following the child. In all cases, it means trying to understand the client’s experiences and to then communicate that understanding to the child for further processing.

Bixler (1949) suggested limits be set for working with children. (These guidelines are also included in the next section.) Hambridge (1955) was much more directive in his use of play therapy. He deliberately set up anxiety-provoking situations to facilitate the child’s resolution of trauma and ego development. This was done, of course, after a therapeutic relationship was established. Ginnott (1959, 1961) believed that therapist reinforcement of limits helped the child to feel secure in being protected by an adult. Clark Moustakas (1959) focused on the child-therapist relationship, but made it clear that the child’s needs dictated the environment.

In the 1960s, behavioral approaches based on learning theory became popular. The behavioral principles of reinforcement and modeling were and are used today to address specific behavioral problems in children (Gil, 1991). Whereas behavioral theory focuses on the behavior, the addition of cognitive theory (Beck, 1976) provides a logical link between thoughts about one’s self and behavior. The cognitive-behavioral therapist considers the client’s perceptions of self, emotions, and behavior as learned phenomenon, which can be changed. Insight into the etiology of behavior is a prerequisite to healthy change (Knell, 1997; O’Connor, 2000).

Filial therapy, developed by Doctors Louise and Bernard Guerney (Guerney, 1964;
Guerney & Guerny, 1982), was intended for use with children with social, emotional, and behavioral problems. In Filial Therapy, parents learn to conduct child-centered play periods with their child, and incorporate these skills into their parenting role (VanFleet, 1994). Perhaps this is what Freud had in mind when he directed Little Hans’s father in techniques to use with Hans.

In more recent years, theories and techniques of play therapy have flourished (Brown & Prout, 1989; Johnson, Rasbury, & Siegel, 1986; Kazdin, 1988, 1995, 1996; Landreth, 1991; Morris & Kratochwill, 1985; Schaefer, 1979; Schaefer & Cangelosi, 1993; Schaefer & O’Connor, 1983; Schaefer & Reid, 1986). Family Play Therapy (Schaefer & Carey, 1994) has its roots in both child and family therapy. Eaker (1986) stated that “family play therapy provides the opportunity for the parent to see in the child’s symbolic play how the child feels about the family and the parent” (p. 243). He contends that family play therapy encourages talking even more than play. Several theorists (Ariel, 1992; Ariel, Care, & Tyano, 1985; Orgun, 1973) believe that play leads to a reduction in anxiety regarding the therapeutic setting.

Not all therapists eagerly embraced the use of play therapy with children. Adler (1927), followed by Horney (1937), Fromm (1947), and Harry Stack Sullivan (1953a, 1953b), placed an emphasis on the therapist’s therapeutic use of self. Less important was the unconscious and/or the past (Johnson et al., 1986).

Play Therapy Guidelines and Techniques

Axline (1947, 1969) formalized guidelines for play therapy. These included: (a) development of a warm, friendly relationship; (b) acceptance of the child as he or she was; (c) permissiveness whereby the child felt comfortable expressing him or herself; (d)
reflection of the child's feelings back to him/her; (e) acceptance of the child's ability to problem solve; (f) allowing the child to lead; (g) an unhurried therapy process; and (h) setting limits only to ensure safety and reality. Bixler (1949) added five limits that the child would not be allowed to do, which were: (a) destroy property; (b) physically attack the therapist; (c) extend time beyond the limit of the session; (d) remove toys from the playroom; or (e) throw toys or other items out the window. These guidelines hold true today (O'Connor, 2000). Though there have not been any guidelines for using play therapy with adult survivors, those set forth by Axline and Bixler would appear to be relevant to use with adult clients as well. In particular, acceptance of the client, warm regard, and belief in the client's ability to solve problems are essential characteristics of a therapeutic relationship in which problem-solving, conflict resolution, and growth can take place.

O'Connor (1991) identified four functions of play. They are: (a) biological, (b) intrapersonal, (c) interpersonal, and (d) sociocultural. A brief explanation of the four functions of play follows.

**Biological**

This function of play occurs in several ways. First, hand-eye coordination and gross- to fine-motor movement result as a child explores his/her environment. Second, though not the focus of therapy, any gain in skill mastery facilitates a positive self-esteem (O'Connor, 1991). Third, energy expenditure and relaxation are additional by-products of play and contribute to the child's well-being. And lastly, through play, the child becomes more aware of his/her body, and this leads the way to self-regulation.
Intrapersonal

Play provides the player with something to do. O'Connor (1991) cautions against dismissing a play session as a failure because “the child did not do anything” (p. 7). If the child plays, he/she is fulfilling the function of play.

A second aspect of play, according to both Erikson and Slobin (as cited in O'Connor, 1991), is experiencing mastery of situations. Through play, the child learns to use his/her mind and body, and to explore the world about him or her. A fear of going to the hospital, for example, can be acted out in the playroom; thus enabling the child to cope with an impending hospitalization.

Conflict resolution is the third aspect of intrapersonal play. Traumatic childhood events may be replayed with more desirable outcomes. The child’s thoughts and feelings may be safely expressed and explored.

Interpersonal

According to O’Connor (1991), play also helps a child develop interpersonal skills. For example, a child initially copes with separation from the primary caregiver through the use of play. Peek-a-boo, hide and seek, and games involving chase enable the child to successfully separate him or herself through the process of individuation.

As the child continues to develop, social skills are learned. He or she learns to share toys and to take turns. In school, the child learns what is expected of him or her in play with other children.

Sociocultural

Through play, children learn about their culture, as well as the roles of people within that culture. Play can be a rehearsal for adult roles. In therapy, the child acts out
the values, beliefs, and behaviors of those adults who have both a positive and negative influence on him or her.

While some of the play functions identified by O'Connor may not seem relevant to therapy with adult survivors, positive regard, success in problem-solving, increased self-esteem, and mastery over adversity certainly are.

**Directive vs. Non-Directive Play Therapy**

Some differences exist between Directive and Non-Directive Play Therapy. In Directive Play Therapy, for example, the therapist pre-plans what will be presented in the session, choosing the toy or activity that will hopefully lead to desired outcome for the session. The room may actually have few other toys and the therapist directs or tells the client how to proceed. A directive approach would be, for example, asking the client to take on certain roles or asking what different figures mean (Schaefer & Cangelosi, 1993).

In contrast, the client leads the way in Non-Directive Play Therapy. It is the client who chooses what toy or activity to engage in during the session. The therapist maintains the core elements of unconditional positive regard, empathy, and congruence. The therapist remains in the play metaphor, unless the client makes a connection to the 'real world'. The roots of Non-Directive Play Therapy may be found in Carl Rogers’s Person Centered Therapy, as well as child development and attachment theory. The therapist does set boundaries on unacceptable behavior, but offers the client a safe, consistent environment and an equally safe therapeutic relationship (Axline, 1947; O’Connor, 1991).
Related Play Therapy Modalities

Dramatic play has been used with children to act out problems and solutions. A psychodramatic technique, mutual storytelling, was developed by Gardner (1971) to facilitate verbal expression of feelings, fears, and solutions. The child is able to construct the story in a manner whereby he or she can have control of the outcome. Gardner (1973, 1981) also developed several games for children and preadolescents to elicit fears and fantasies.

Bibliotherapy, or the use of children’s literature, has been used to help children cope with difficult situations (Cohen, 1987, 1993).

Art therapy has been used with children to capture feelings, thoughts, and tensions, which the child may not be able to express verbally (Klepsch & Logie, 1982).

Drawing is a common play activity among children. Children draw from their experiences and may express troublesome experiences or feelings as a way of communicating what they are unable to verbalize. Burns and Kaufman (1970) developed the “Kinetic Family Drawing” as a tool for understanding children. Here, a child is asked to draw a picture of his or her family doing something. Who is included in the picture, the interaction of members, expressions, significant inclusions or exclusions, physical characteristics of the members, and the child’s own self-portrait tell a story of what it is like to be a member of that family, especially for the child who is drawing the picture. Burns (1987) later developed the projective technique of “Kinetic-House-Tree-Person” drawings to assimilate the family in action. Similar to the “Kinetic Family Drawing,” the child is asked to draw a house, a tree, and a person on the same page with some activity being carried out. Burns used this technique with both children and adults. His
Kinetic-House-Tree-Person Drawings (K-H-T-P) An Interpretation Manual (1987) includes drawing examples from children and adult clients. Interestingly, 41 of the 51 drawings that are included in the K-H-T-P manual are from adult clients.

Music therapy may bring about physiological changes, as well as changes in social interactions (Moreno, 1985). Lyrics from a familiar song may facilitate memory of a past event. With the guidance of a skilled therapist, unpleasant and even painful experiences may be processed.

In ancient Greece, dance was used to express one’s self. Dance therapy can help a person develop greater body awareness and change distorted body images (Loman, 2005).

Recreational therapy (RT) has been used with clients of all ages. Recreational therapy has as its goal rehabilitation, as well as prevention and education (American Therapeutic Recreation Association, 2005). While RT is used to treat clients with physical problems, RT is also used to treat emotional problems caused by trauma and abuse. Activities are numerous, from horseback riding to swimming, hiking, playing outdoor games, playing board games, sports, cycling, arts and crafts, and so forth.

According to Ryan (1989), “play enables us to transcend the normal every day world by inserting us into the time structure of the playful universe which has the specific quality of offering a taste of eternity” (p. 128). Play needs no purpose or end. The important aspect of play is the meaning attributed to it. One of the goals of therapy is to assist the client in finding meaning and understanding in his or her life.

**Play Therapy With Adults**

To deal with shame and guilt, Ellis (1977) developed a technique called shame
attacks, whereby the client is encouraged to act out a feared behavior. The client is helped to realize that he or she survived the situation and remained intact. Ellis also used humorous rational songs to lighten the seriousness of the client’s situation and fears. With this technique, the client writes a humorous song that reflects his or her problem(s) in a less serious manner. Gladding (1992) believed that play and humor, as well as the creative arts, enabled clients across the lifespan to gain perspective on a problem and solve it in a more realistic manner. For those adults stressed by too many demands, Gladding offered playful approaches in therapy as a way of gaining space and perspective. Corey (1991) believed that even a depressed adult client could benefit from play and humor in his or her life. Amusement at life’s tribulations may go a long way in finding a solution, peace, and contentment.

Expressive therapies, such as play, art, drama, music, poetry, dance/movement, and sandtray help clients of all ages express feelings and emotions (Malchiodi, 2005). Hagood (2000), however, cautioned against using artwork for diagnoses, saying that it is the process of art-making that is the therapeutic value. Psychodrama with trauma survivors provides a medium of expression and release that offers hope to the survivor in resolving and restructuring their life (Kellermann & Hudgins, 2000).

Play therapy with adult clients can foster increased self-esteem, sense of well-being, and joy (Ward-Wimmer, 2003). As Gladding (1991) explained, in a stressful environment, play can release the creative inclinations that lead to solutions and provide the realization that one is not alone in his or her feelings of being overwhelmed and stressed (Ward-Wimmer, 2003). According to Landy (2003), play is therapeutic for adults in healing trauma, but the adult may not be able to play as freely as a child. Adult
play may be more cognitively based in telling stories and/or alternative scenarios. When the adult is able to regress or play as a child, he or she may, for example, take on the persona of an inanimate object. This enables the client to gain a sense of control. Upon returning to adult consciousness, the client can then reflect upon the play and discuss its significance. Carey (2006) explained that by using expressive and creative arts methods of treating trauma survivors, the therapist can tap into areas of the brain that verbal therapy alone may not reach.

Glover (1999) emphasized the necessity of a non-threatening environment in order for substance abuse clients with a history of incest to freely express their feelings and emotions. Play therapy allows the client the opportunity to express shame, guilt, fear, and anxiety without the threat of rebuke. It assists the client in conflict resolution. In particular, Glover suggests the use of psychodrama and puppets with adult clients. As with children, the adult client may be asked to bring to treatment a saved love object, such as a teddy bear or the recreation of a lost love object. This object provides an anchor through which the wounded client may speak. Glover concluded that talk therapy may be less effective with adult incest victims, because due to dissociation, they may not have verbally worked through the experience(s). Memories are primarily visual. Play allows the client to safely experience and thus work through the trauma.

Sanderson (2006) offered a comprehensive text on counseling adult survivors of child sexual abuse that included theory, as well as practical advice. She reiterated the value of the therapeutic relationship in working with adult survivors of childhood abuse, while addressing the client's need for boundaries, transference issues, and the avoidance of secondary traumatic stress. Although, this brief review on Play Therapy with adults is
rich in clinical wisdom and knowledge of the authors/clinicians cited, additional research is needed to more fully establish the use of play therapy with adult survivors of childhood abuse.

**Long-term Effects of Sexual Abuse**

The long-term effects of childhood sexual abuse permeate the victim's entire life: the sense of self, intimate relationships, sexuality, the ability to parent, to work, to love, to enjoy one's physical and mental health (Bagley, 1991; Faulkner, 1996; Roth & Batson, 1997; Simonds, 1994). Because love and trust were betrayed, the child learned that he/she could not rely on feelings (Gil, 1988; Herman, 1992; Stean, 1988). Adults in the child's life were out of control, and expression of feelings often led to violence, pain, and/or destruction. Anger meant beatings or throwing of objects (Bass & Davis, 1988). The child soon learned to block physical pain and, subsequently, all feelings. Many children learned to leave their bodies to avoid feelings of pain, betrayal, and conflicting sensations of arousal (Chu et al., 1999; Lewis et al., 1997). Other children viewed adults as all good or all bad. For example, the child may separate in his or her mind the abusive male from a father who loves and protects. The father is perceived as good and the child as bad (Browne & Finkelhor, 1986). This splitting served as a coping mechanism. Such a lack of integration may lead to Dissociative Identity Disorder in adulthood (Bass & Davis, 1988).

In order to survive, the child attempted to cope through minimizing, rationalizing, denial, or repression (Ross, 1997). Chaos served to create control for some. By creating a crisis, others were forced to respond (Walker, 2000). Thus, negative reinforcement, in turn, created the desperately needed sense of control.
Survivors are good at creating and resolving crises (Bass & Davis, 1988). Escape through fantasy may manifest itself in adulthood as the survivor escapes from reality, mental illness often ensuing. Anorexia and bulimia are seen in adult survivors as a way of controlling a developing body. Overeating has been noted as a way of avoiding sexual relationships (Bass & Davis, 1988). Suicidal ideation, homicidal ideation, self-destructive and addictive behaviors are frequently seen in adult survivors (Ross, 1997). Anxiety disorders, depression, posttraumatic stress disorder, somatoform disorders, and personality disorders have a high correlation with childhood sexual abuse (Roth & Batson, 1997).

**Current Treatment Modalities**

A major drawback in treating adult survivors has been the multiple symptoms that adult survivors report when they are treated in the medical and mental health facilities (Ross, 1997). Because each survivor exhibits his/her own unique cluster of symptoms, the treatment generally focuses on those specific symptoms and the subsequent diagnoses. For example, depression is common among survivors (Gladstone et al., 1999; Levitan et al., 1998; Weiss et al., 1999). Depending on the clinician, the approach to treating the adult survivor with depression can be varied. It has been only in recent years that Dissociative Identity Disorder (DID) has surfaced as a predominant diagnosis in adult survivors (Chu et al., 1999; Lewis et al., 1997). Posttraumatic stress disorder (PTSD) is a frequent diagnosis seen in adult survivors (Gelinas, 1983; Greenberg & van der Kolk, 1987; Herman, 1992; Ross, 1997; Roth & Batson, 1997; Simonds, 1994). Treatment approaches for clients with both DID and PTSD also vary depending on the therapist and, in some cases, the treatment center.
Cognitive theory underlies many treatment strategies. Adults are expected to gain insight and get in touch with their feelings. Journaling is a popular technique that is utilized (Bass & Davis, 1988; Ross, 1997). Eye Movement Desensitization and Reprocessing (EMDR) therapy, developed by Shapiro, has resulted in successful treatment for clients diagnosed with PTSD (Shapiro & Forrest, 2002). Parnell (1999) proposes EMDR as the treatment of choice for adults abused as children.

Many survivors of childhood sexual abuse have great difficulty expressing themselves (Glaister & McGuinness, 1992). Art (Adamson, 1984; Esman, 1988; Glaister & McGuinness, 1992; Liebmann, 1986), music (Moreno, 1985; Shulberg, 1981) and play (Blatner & Blatner, 1997; Gil, 1991) provide a medium for expression of painful feelings, thoughts, and emotions. Gladding (1992) has promoted the use of the creative arts: music, dance, imagery, visual arts, literature, drama, play, and humor for use with clients of all ages.

Group therapy has been suggested for women sexually abused as children (Tsai & Wagner, 1978). The value of group support is reinforced in the treatment thrust advocated by Ross (1997). Ross has developed a trauma program that includes: (a) cognitive therapy which allows clients to identify conflicts and unlearn cognitive distortions; (b) expressive techniques to encourage self-awareness and processing of affect; and (c) a didactic component aimed at understanding the effects of trauma and co-morbidity. Clients are guided in anger management, grief work, and processing of fears and the trauma experience. Clients are encouraged to develop a support system and to learn to control impulses. Ross suggests such activities as shredding paper, making mud pies, jumping rope, batting balloons around the room and popping them, and having a
pillow or snowball fight--activities generally enjoyed by children--as a means of dealing with anger.

In summation, treatment for adult victims is as varied as the symptoms presented by the adult survivors.

Research on Adult Survivors

As stated in the previous section, research in the past 10 years has generally focused on describing the multiple symptomatology that adult survivors present (Chu et al., 1999; Gladstone et al., 1999; Levitan et al., 1998; Lewis et al., 1997; Weiss et al., 1999). Chu and his colleagues (1999) studied 90 female patients admitted to a trauma unit. They concluded that early chronic childhood abuse is related to high levels of dissociative symptoms, including amnesia regarding abuse. The incidence of dissociation in patients reporting abuse was significantly higher than those who did not report abuse. Physical and sexual abuse correlated significantly with amnesia. The 1997 study by Lewis and her colleagues concurred about the relationship between early childhood abuse and dissociative identity disorder. This qualitative study involved a retrospective look at the medical records of 11 men and one woman. In all 12 cases, collaboration from several sources affirmed the abuse-engendered development of DID.

In the study by Gladstone et al. (1999), 269 inpatients and outpatients with the diagnosis of major depression responded to a structured clinical interview and self-report questionnaire. Forty of the women and six men reported childhood sexual abuse. Through multivariate analyses, the researchers were able to conclude that childhood sexual abuse is not directly related to depression, but more likely associated with a
dysfunctional home environment and a greater chance of developing borderline personality. Dysfunctional home environment and the development of borderline personality, however, were associated with a greater incidence of depression in adulthood. Weiss and others (1999) reviewed studies correlating childhood sexual abuse with the development of major depressive disorder. Their conclusion supported the hypothesis that childhood sexual abuse is a major stressor that may predispose an individual to the development of major depression in adulthood.

Browne and Finkelhor (1986) reported in their review of research on the effects of childhood sexual abuse that long-term effects of child sexual abuse include depression, anger, aggression, self-destructive behavior, poor self-esteem, substance abuse, and sexual maladjustment. Due to the wide range of symptoms and pathology, no model for treatment was suggested, however. As in this study and previous studies in the last decade, attempts to describe and to more fully understand the adult survivor have been made. No mention is made in any of these studies regarding the use of play therapy with adult survivors.

Simonds (1994) writes about the use of nonverbal modalities in the treatment of adult survivors of childhood sexual abuse. Her knowledge and insight are based on a review of literature as well as her own experiences in working with adult survivors of childhood sexual abuse. Techniques that she suggests include the use of art, drawing, visual imagery, and body movement.

Walker (2000) has studied battered women for the past 20 years. She believes that partner violence is a learned behavior. Violence experienced in childhood spawns a cycle of continued violence in adulthood. Breaking the abuse cycle is her major focus.
A follow-up study, assessing the long-term effects of EMDR, was conducted by Edmond and Rubin (2004). Findings suggested that the therapeutic benefit of EMDR can be maintained over an 18-month period and may be more time-effective in trauma resolution than other treatment modalities. In another study by Edmond, Sloan, and McCarty (2004), perceptions of adult survivors’ EMDR therapy and eclectic therapy were investigated. Clients felt that they achieved greater trauma resolution with EMDR, but valued their relationship with the therapist more in the eclectic approaches. The greater satisfaction in the therapeutic relationship correlated positively with learning more effective coping skills.

Although there is little research on treatment approaches for adult survivors of CSA, one study looked at clinical decision-making strategies of marriage and family therapists in treating adult survivors (Higgins Kessler, Nelson, Jurich, & White, 2004). Fifteen of 75 therapists completed the study, which involved responding to five different scenarios and identifying areas that should be explored when a client discloses a history of childhood sexual abuse. The extent to which the abuse was dealt with in therapy depended largely on the presenting problem. If the abuse was the presenting problem, it received more attention, compared to less regard if it was mentioned only as part of the client’s history. When a history of abuse was introduced during couple’s therapy, therapists made their decision whether to continue with couple’s therapy, couple’s and individual therapy, or just individual therapy based on the effect on the individual client’s and the couple’s present functioning. The researchers admit that the participant size limited generalization, as did the fact that the therapists may not have expertise in working with adult survivors.
Although play therapy is used extensively in working with abused children, no studies were found that suggested play therapy in treating adult survivors. Many clinicians have alluded to the creative arts (Adamson, 1984; Bass & Davis, 1988; Blatner & Blatner, 1997; Esman, 1988; Gil, 1991; Gladding, 1992; Glaister & McGuinness, 1992; Moreno, 1985) in working with adult survivors, but no mention is made of specific play therapy techniques or their effectiveness with adult clients. It appears to be a logical premise that if play therapy is effective with children who are sexually abused, then play therapy might be an effective treatment approach to adult survivors who were sexually abused as children.

**Summary of Chapter 2**

In chapter 2, a historical perspective of play therapy with children, including the four functions of play – (a) biological, (b) intrapersonal, (c) interpersonal, and (d) sociocultural identified by O’Connor (1991) – was followed by a discussion of play therapy with adults and related modalities. The long-term effects of sexual abuse and current treatment approaches for adult survivors were next discussed.

Finally, literature reflecting research on adult survivors was presented. Research in the past has focused on describing symptomatology. Simonds (1994) advocates nonverbal techniques for treating adult survivors. Few studies, however, have explored treatment strategies and measured outcome. One study (Edmond & Rubin, 2004) looked at the use of EMDR in treating trauma patients. Although the researchers felt EMDR was effective, a study by Edmond et al. (2004) stressed the importance of the therapeutic relationship. Clients felt they gained greater trauma resolution with EMDR than other approaches, but
emphasized the importance of the relationship with their therapists in developing more effective coping skills.
CHAPTER 3

METHODOLOGY

Introduction

The purpose of this study was to investigate the use of play therapy with adult survivors of childhood sexual abuse. This chapter describes the design, sample selection, pilot study, procedures and instrumentation for data collection, and the method of data analysis.

Design

Because little is known about the use of play therapy with adult survivors of childhood sexual abuse, it was deemed most appropriate to use an exploratory approach in which therapists who treat adult survivors were surveyed. Answers to the following research questions were sought through triangulation of initial qualitative, quantitative, and subsequent qualitative data collection and analysis:

1. To what extent is play therapy used by therapists who work with adult survivors of childhood sexual abuse?

2. What techniques are commonly used by therapists who work with adult survivors of childhood sexual abuse?

3. How do therapists who use play therapy with adult survivors of childhood sexual abuse rate the effectiveness of play therapy techniques?
The study was conducted in three phases. The first phase consisted of a qualitative pilot study in which six therapists who work with adult survivors were interviewed. Data obtained from the pilot study were used to develop a survey for the second phase. This phase was quantitative in that the survey developed during Phase 1 was sent to potential participants in Phase 2. Phase 2 respondents selected for a subsequent interview in Phase 3 were chosen based on: (a) if he/she worked with adult survivors, and (b) if he/she was willing to be interviewed, as indicated by completing Question 11, and including contact information. This final qualitative phase (Phase 3) commenced with the selection of the participants and concluded with the final data analysis. It was postulated that by first identifying key questions during Phase 1 (pilot study), Phase 2 would add a broader perspective and understanding to the concept being studied. Phase 3, in turn, would assist in conceptualizing the phenomenon under study.

**Sample Selection**

**Phase 1 Pilot Study**

Of the six pilot participants, three were women and three were men. Four of the therapists were in private practice; one worked in a university setting; and the sixth participant worked in an in-patient psychiatric hospital. All of the therapists had over 5 years of experience in working with adult survivors. Two had a Ph.D. degree in psychology; one had a M.A. degree in Counseling; and three had MSW degrees. Out of this group, one therapist described herself to be primarily an art therapist.

Two of the participants for the pilot study included therapists who worked, or had worked, in the Trauma Program at Forest View Psychiatric Hospital in Grand
Rapids, Michigan. The rationale for using therapists at Forest View was that these therapists, under the direction of Dr. Colin Ross, author of the *Trauma Model* (2000), already used techniques in their treatment that may be classified as play therapy. The Director of the Trauma Program at Forest View was contacted by phone for names of therapists who might be willing to be interviewed. Three potential pilot study participants were, in turn, contacted by phone to ask if they would be willing to participate in the study. One was on medical leave and could not be reached. Another therapist had left the hospital for private practice, but a forwarding phone was available and that therapist agreed to a phone interview. The third therapist agreed and was interviewed in person.

The Director of the Counseling Center at Ferris State University, in Big Rapids, Michigan, was then contacted in order to identify therapists who worked with adult survivors at their center. One therapist was pointed out and subsequently interviewed in person. Additional participants were selected from therapists who identified themselves as having expertise in working with adult survivors of childhood abuse in the *Behavioral Health and Wellness Service Providers Directory* of Northwest Michigan (2002). These potential participants were contacted by phone and/or email to inquire about participation and to establish an interview time. Three participants were obtained in this manner. Participants were purposively selected because of their expertise in working with adult survivors.

**Phase 2 Participants**

Participants for Phase 2 were drawn from two sources: (a) The Association for Play Therapy (APT), and (b) *Psychology Today's Therapist Directory 2003 Midwest.*
The Association for Play Therapy (APT) listed 434 registered play therapist supervisors in the directory who had provided email addresses. Minimal requirements to be a registered play therapist supervisor are: (a) a master’s degree, which must include content in “child development, theories of personality, principles of psychotherapy, child and adolescent psychopathology, and legal, professional, and ethical issues” (APT, 2003, p. 5), (b) at least 150 clock hours of play therapy instruction, (c) “national/regional medical/mental health board licensure or certification” (APT, 2003, p. 5), (d) 5 years of direct patient contact post-master’s, (e) 500 hours of supervised play therapy experience, (f) an additional 500 hours of play therapy experience, and (g) 4 hours of supervisor training. Because of their experience with play therapy, it seemed that this was an appropriate population to sample.

The Psychology Today Therapy Directory (2003) listed 90 therapists who identified themselves as working with sexually abused clients and who provided email addresses. Utilizing this directory potentially afforded an unbiased sample since it was unknown if this population used play therapy or other modalities in treating adult survivors.

All of the 434 registered play therapist supervisors and the 90 therapists listed in The Psychology Today Therapist Directory (2003), for a total of 524 potential participants, were contacted by email, requesting participation in the study. See Appendix A for a copy of the email notification.

One hundred and thirty-four emails were returned, undelivered, with addressee unknown. This brought the sample population down to 390. One hundred and ten therapists responded by email, applauding the study, but disqualified themselves
because they: (a) worked with children only and not adult clients; (b) were retired; or (c) not currently seeing clients in therapy. This further reduced the pool to 280.

A second email request was sent to potential participants who had not previously responded. See Appendix A. Thus, for Phase 2, a total of 37 participants completed the online survey. It is noted that 22 of the 37 participants were Registered Play Therapist Supervisors, experts in the field. Six of the 37 also participated in the pilot study as well.

Phase 3 Participants

Of the remaining 31, only 16 identified themselves and listed contact information. All 16 were contacted. Several attempts to reach one potential participant failed. The remaining 15 were interviewed.

In the end, the 21 participants in Phase 3 included 12 who were Registered Play Therapist Supervisors and 9 who were non-APT therapists (which included the 6 therapists who had also participated in Phase 1). The certification as a Registered Play Therapist Supervisor denotes knowledge and clinical expertise in the use of play therapy. Their in-depth interviews provided input that was current and insightful.

What is important in qualitative research, according to Lincoln and Guba (1985), is that data are collected until a point of saturation or redundancy occurs. I believe data saturation and redundancy occurred early in the interviewing process, as repeated themes, such as rationale for using play therapy with adult survivors, techniques, trust issues, and the importance of an early childhood trauma assessment arose. Thus, a combined total of 6 pilot interviews and 15 study interviews sufficed to meet the research objectives. Four participants were male; 17 were female. Geographical
representation from all correspondents included 25 states and the District of Columbia. Interviewees came from California (2), District of Columbia (1), Illinois (1), Maine (1), Michigan (7), Minnesota (2), Missouri (1), New York (1), Ohio (1), Oregon (1), Pennsylvania (1), and Texas (2).

Data Collection

Phase 1 Pilot Study

The pilot study served three purposes. The following goals were accomplished during this period.

1. To realize an initial conceptualization of the phenomenon under investigation
2. To develop a quantitative survey to collect demographic and categorical variables
3. To formulate target questions for interviewing of Phase 3 participants.

Informed Consent

Prior to each pilot interview, participants signed an informed consent form. A copy of the form is contained in Appendix B. To maintain anonymity, completed forms have been retained by the researcher, but are not included in this paper.

Recording

After signing the informed consent form, participants were asked if they would consent to having the interview audio-taped. All of the participants agreed. Verbatim, handwritten notes were taken, which were transcribed within 24
hours of the interviews. The cassette tapes and handwritten notes were combined to provide an accurate record of the interviews.

**Procedure**

A preliminary survey tool was used to gather data regarding the percentage of clientele who presented as adult survivors, the theoretical and academic backgrounds, specific techniques used, and the therapists’ perception of play therapy effectiveness in treating adult survivors. The therapists were asked to review the survey instrument and were encouraged to offer suggestions. Based on their feedback and review from a quantitative statistician, the instrument was revised and placed online at www.totalpersons.com for Phase 2 participants to complete. After the website was available for access of the survey, the pilot participants were contacted by phone and asked to complete the revised survey online. All of them did. See Appendix C for a copy of the survey.

Next, participants in the pilot study were asked the following open-ended questions:

1. How do you approach therapy with adult survivors of childhood sexual abuse?
2. How did you come to use play therapy techniques with adult survivors?
3. How do you determine which clients you will use play therapy techniques with?
4. Would you describe a session where you used play therapy techniques?
5. Why did you choose to use this technique at this time?
6. Are there other techniques that you frequently use?
7. Is there anything else that you would care to share with me about play therapy with adult survivors?

As with the survey, pilot participants were asked to comment on the completeness of the interview questions and if they had any suggestions. It became apparent that the term play therapy, when used with adult therapy, was confusing to some. Participants were asked what would make the topic more clear in their mind. The term experiential was added to the title and initial inquiry on the survey as a result of this feedback. The interviewing approach in Phase 3 adopted this terminology. Questions 2 through 7 became the format for the Phase 3 interview guide.

Content Validity

Unique to qualitative research methods is the simultaneous data collection and analysis (Polit & Beck, 2004; Polit, Beck, & Hungler, 2001). The qualitative data obtained from the participants in the pilot study (Phase 1) were processed in this manner. After each interview was transcribed into a formal document, containing questions and participants’ responses, I reviewed each record, highlighting concepts and themes.

A nursing faculty member, who had 10 years of direct-care experience in pediatrics and pediatric critical care and 21 years of experience in teaching pediatrics, and thus, considerable knowledge of child abuse, agreed to listen to the audiotapes and review the interview records for content. This faculty member had also served as a community educator for troubled families and managed a pediatric intensive care unit, in which she instigated play therapy for pediatric patients and their families. The
philosophy for this unit was based on research supporting play therapy for hospitalized children with cancer, chronic disease, abuse, trauma injury, burns, and so forth. The premise was that if the child dealt with issues related to his or her illness while in the hospital, post-hospital outcome would be improved. This faculty member was a doctoral candidate at the time of the review. To control for bias, my comments and theme identification had been deleted from the records reviewed by this faculty member. A discussion by the two of us followed her review and agreement was reached regarding accuracy of documentation (agreement of audiotape and typed interview record) and concept/theme identification.

The faculty member then reviewed the survey instrument. According to her, both the survey and interview questions appeared to be valid instruments for the content under investigation. As was mentioned earlier, Phase 1 pilot participants, who were therapists with experience in working with abused clients, were also asked throughout the process for feedback on the adequacy of the data collection tools. Their feedback was used in both the survey development and in the development of the interview questions.

Phase 2 Data Collection

Phase 2 provided a means of gathering quantitative data and recruiting participants for Phase 3 interviews. To accomplish these tasks, the survey, developed in Phase 1, was placed online at: www.totalpersons.com. Emails were sent to potential participants, described previously in the sample selection, inviting their participation in the survey. An online version of the Informed Consent (see Appendix B) was included in this email invitation.
Survey Instrument

The Play/Experiential Therapy With Adult Survivors of Childhood Sexual Abuse Survey (Roehrig, 2004) was evaluated for ease of administration and content validity by therapists in the pilot study. See Appendix C for a copy of this survey. The revised edition contained 10 questions. The first 2 questions were forced-choice answers:

1. Do you currently use play or experiential therapy with adult survivors of childhood sexual abuse? This required a yes or no selection.

2. What percentage of your practice is with adult survivors? Five percentage categories were offered.

Questions 3 through 9 (degrees, certifications, theoretical orientations, developmental theory influences, therapy approaches, client diagnoses, and specific techniques) presented several choices, plus an ‘other’ category for write-ins. Question 10 provided a Likert scale for rating the effectiveness of play therapy when used with adult survivors.

The online survey was programmed to accept responses only; thus, participants had the option of remaining anonymous. Names and email addresses did not automatically appear on the survey. Some chose anonymity. An option was provided, however, for those who wished to participate in the Phase 3 interviews. These participants were asked to include their name, phone number, and email address. The option of remaining anonymous or of identifying oneself in order to participate in Phase 3 was explained in the email letter and on the survey. A reminder email was
sent to potential participants thanking those who may have anonymously participated and encouraged others to participate.

Phase 3 Data Collection

All of the therapists who identified themselves and provided contact information were contacted in accordance with their preferred method of contact (phone vs. email). Repeated attempts to reach one of the therapists failed. A time for a phone interview was established with the remaining 15 subjects.

Each participant was asked the same open-ended target questions and in the same order. Participants were given ample time to elaborate on their responses, and because I am skilled in therapeutic communication, I facilitated exploration by using my interviewing skills. Whereas the length of the pilot interviews, which included dialogue on the Phase 2 survey tool and interviewing questions, tended to be longer, averaging 1 to 1 1/2 hours in length (the longest being over 3 hours), the Phase 3 interviews averaged 45 minutes in length. The most likely reasons for the shorter length of interview times for Phase 3 are: (a) preliminary discussions regarding interview expectations at the time that the interviews were arranged; (b) a focused interview scheduled, based on Pilot feedback; and (c) the fact that Phase 3 participants had already completed the Phase 2 survey instrument.

Participants’ names and contact information in all three phases were recorded only on the confidential collection tools retained by the investigator and do not appear anywhere is this study.
Data Analysis

Because it was essential that data from Phase 1 (the Pilot study) be analyzed before proceeding to Phase 2, and Phase 2 data needed to be analyzed before going on to Phase 3, the analysis of data will be discussed in that order.

Phase 1 Analysis

Phase 1 had three purposes: (a) to gain an initial understanding of the phenomenon under investigation, (b) to develop the online survey for Phase 2, and (c) to develop interview questions for Phase 3. Thus, participants in Phase 1 were interviewed and then asked to review the developing survey for adequacy of content coverage and ease of administration. Their feedback was used in the development of the online survey administered in Phase 2 and interview questions used in Phase 3.

The verbatim transcriptions of the pilot interviews were reviewed for themes and categories by myself. A copy of the transcripts, minus the coding used, was then given to a nursing faculty colleague, currently involved in educational research. This faculty member had 21 years' experience as a pediatric nurse educator and clinical experience in working with abused children. As a nurse manager, she instigated play therapy in a pediatric unit and was well versed in research on both child abuse and play therapy. She reviewed the transcripts and made notations of themes and categories. A third set of transcriptions, without coding, was given to a nursing graduate student, who was enrolled in a research course at the time and pursuing advanced course work in statistics. A discussion among the three of us followed the three reviews, and agreement was reached regarding the coding used to capture the central themes and categories.
Finally, the survey instrument for Phase 2 and interview schedule for Phase 3 were shared with the faculty member and graduate student. Both agreed that the phenomenon under investigation was adequately represented by the two methods of data collection. A quantitative statistician and faculty member was consulted for suggestions on the survey instrument. Specifically, he was asked to review the instrument for clarity and format. After discussing the intent of the survey with the statistician, he was asked if there were any other questions that he would suggest be asked. No further questions were added. The survey and interview questions were also discussed with Dr. Cooper, the statistician who developed the Theme Analysis for Word Rich Data procedure. Although Dr. Cooper lacked knowledge of play therapy, his expertise in both quantitative and qualitative research made him an appropriate resource.

In summation, analysis of Phase 1 interviews and feedback on the study questionnaire from therapists in the Pilot study, a faculty content expert, a nursing graduate student, and two statisticians provided initial conceptualization of the phenomenon under investigation, a pilot-tested survey for administration in Phase 2, and target interview questions for Phase 3.

Phase 2 Survey Instrument Analysis

When the topic under investigation is not well established or is lacking in empirical research, an exploratory approach is necessary (Gillis & Jackson, 2002). Therefore, data collected to answer the first research question in this study, “To what extent is play therapy used by therapists who work with adult survivors of childhood sexual abuse?” were descriptive in nature. Participants were asked to select the
percentage that best described their practice with adult survivors. Frequencies were tabulated to describe the data obtained. The second research question, which focused on specific techniques used with adult survivors, required nominal level measurement. Thus, frequencies were tabulated to describe this set of data as well. The third research question, "How do therapists who use play therapy with adult survivors of childhood sexual abuse rate the effectiveness of play therapy techniques?" was measured on a Likert scale. Central tendency, specifically, the median and mode, were determined to address this question.

A correlation coefficient was calculated, using the Pearson product-moment correlation coefficient formula to evaluate the relationship between the percentage of practice with adult survivors and the therapists' perceived effectiveness of using play therapy techniques with adult survivors. To evaluate the differences in perceived effectiveness of play therapy with adult survivors between therapists with a doctoral degree and those with a master’s degree, an independent samples t test with equal variances was calculated.

Phase 3 Qualitative Analysis of Interviews

In Phase 3, the Theme Analysis for Word-Rich Data (Cooper, 2003) approach was used. This approach involved an analysis team, with the help of a skilled facilitator. Team members included three independent thinkers: (a) a psychologist, with experience in working with sexual abuse victims, (b) an informatics specialist, with a doctorate in educational leadership, and (c) a nursing faculty member. Michael Cooper, author of the Theme Analysis method, served as facilitator. A copy of this
method may be reviewed in Appendix D. The session was videotaped for later reference.

Data were prepared for the team by myself in the following manner:

1. The verbatim interviews were transcribed.

2. Participants' and interviewer's comments were designated.

3. The dialogues were summarized according to the interview question and corresponding response. The summaries, containing both question and response, were then placed on 5-by-8 cards.

4. Cards were then sorted according to interview questions, so that all of Question 1 responses were placed in a pile, Question 2 placed in a pile and so forth.

5. The sorted cards were then placed on an accessible blank wall with 'teacher's putty' in columns according to the interview question.

The team members initially walked around the room, moving cards to other columns; creating new categories and subgroups as they deemed appropriate. Team members were told by the facilitator that they may change the cards in any category as often as they felt necessary to properly define a theme. No talking was allowed, however, during this initial clustering. The facilitator ended the initial clustering when categories stabilized, that is, no further movement of cards was apparent and team members sat down. Team members were then invited to discuss the rationale for their choices.

The facilitator led the discussion as team members named the new categories. Team members identified and analyzed inter-relationships among the themes.
Members shared why they had changed another team member's placed card and how themes emerged as the cards were changed. The facilitator conducted a debriefment at the conclusion of the session. This consisted of asking the team members and myself for our opinion on the process and what we had learned from the process. All team members and I felt that the categories were distinct and appropriately named.

Summary of Chapter 3

An exploratory method, using a triangulation of an initial qualitative, quantitative, and subsequent qualitative approach, was used to explore the use of play therapy with adult survivors of childhood sexual abuse. A brief survey and in-depth interviews were employed to collect data from therapists who work with adult survivors. The intent was to describe the characteristics of therapists who use play therapy with adult survivors and glean an understanding of the phenomenon under investigation. Specifically, how did the therapists come to use play therapy with adult survivors and what techniques did they find successful? A process called Theme Analysis for Word-Rich Data (Cooper, 2003) was used in identifying concepts and themes from interview data.
CHAPTER 4

RESULTS

Both qualitative and quantitative results obtained from the pilot and the main study are presented in this chapter. Although the results of the pilot study served as a guideline in developing the main study, the data are presented here separately, as well as discussed as a whole, in order to provide a complete picture, and ultimately, a model for practice (presented in chapter 5).

Results of Phase 1 Pilot Study

Six therapists participated in the pilot study. (See Appendix D for the interview questions and Appendix C for a copy of the survey instrument.) Three were women and three were men. Four of the therapists were in private practice; one worked in a university counseling center; and one worked in a psychiatric hospital. All of the therapists had over 5 years of experience working with adult survivors. Two had a Ph.D. degree in psychology; one had a M.A. degree in Counseling; and three had MSW degrees.

Of the 6 pilot participants, only 1 said she did not use play therapy with adult survivors. However, during the interview, she reported using interventions that were later classified by the study participants as play therapy techniques. Five out of the 6 rated the effectiveness of using play therapy with adult survivors as $5 = \text{Very effective}$. The 6th person rated the effectiveness of play therapy as 4 (between
moderately effective and very effective). The Likert scale ranged from 1 = Ineffective, through 3 = Moderately effective, to 5 = Very effective. Interestingly, the one person who denied using play therapy with adult survivors rated its effectiveness as a 5.

Theoretical Orientation

When asked what their theoretical orientation was, 4 of the pilot participants selected behavioral orientation, 5 subjects selected cognitive orientation. Selection in both behavioral and cognitive categories by 4 of the therapists suggests a predominance of cognitive behavioral orientation in the pilot subjects. Additionally, 2 subjects selected Dr. Colin Ross’s Trauma Model and one participant chose Art Therapy. See chapter 1 for definitions of these theories.

Developmental Theory

When the therapists were asked which developmental theories had the most influence on their practice, the pilot study therapists responded as follows: (a) Erickson and Mahler, 4 each; (b) Sullivan and Trauma Model, 2 each; and (c) Piaget and Art therapy, 1 each. See chapter 1 for definitions of these theories.

Overall Approach to Therapy

In an attempt to determine the predominant approaches to therapy that are used with clients who are adult survivors, participants were asked to select their predominant approach to therapy. It is very possible that therapists might have received theoretical orientation to therapy in their academic preparation that now differs from their actual approach to therapy. Therefore, participants were asked to
identify both their theoretical orientation to therapy and approach to therapy. The instrument was constructed in such a manner that multiple selections were possible. Indeed, multiple selections were made. Five of the 6 pilot participants listed cognitive therapy as their predominant approach to therapy. Three selected an overall behavioral approach to therapy. These same 3 also selected cognitive for a combined cognitive-behavioral approach. Two pilot participants selected interpersonal approach to therapy. Under the ‘other’ category, 2 participants selected Trauma Model; 1 selected Art Therapy; and 1 selected what she self-named, Joy Therapy (defined by this participant as finding joy in your life), as their overall approach to therapy.

Presenting Problems

Participants were asked to select the most frequent presenting problems of their clients. The instrument allowed for more than one choice since clients often have more than one diagnosis. Multiple choices were selected. All 6 subjects selected anxiety, Post Traumatic Stress Disorder (PTSD), depression, and sexual abuse. Five therapists also selected Dissociative Identity Disorder (DID); 4 subjects also selected eating disorders; and 4 also chose substance abuse as frequent presenting problems. Trauma, empowerment issues, phase of life issues, boundary issues, and marital issues were other presenting problems mentioned.

Techniques Used in Therapy

A variety of techniques for use with adult survivors was selected on the survey and reported during the interviews. Each participant could choose as many as were applicable. All 6 participants in the pilot study selected anger management and
role-playing as the therapeutic techniques they used with their clients. Five therapists chose the broad category of physical activity. Four therapists utilized art, and 4 used journaling as therapeutic techniques. Three participants selected psychodrama. Two participants selected therapeutic games, and 2 selected finger painting. The use of imagery and humor were each selected twice. Two therapists selected dance. Each of the following was reported by at least one therapist: (a) puppetry, (b) music, (c) hypnotherapy, (d) reframing, (e) insight therapy, (f) puzzles, (g) story telling, and (h) watching videos.

It is interesting to note that while 4 of the participants had previously selected behavioral theory as their initial framework for therapy, only 2 of them selected behavioral therapy as an approach in working with adult survivors. These 2 selected a cognitive approach to therapy as well as behavioral. The more expressive techniques, such as the general category of art, sand tray, psychodrama, and finger painting, appear inconsistent with a behaviorist approach. In reviewing the pilot interviews, however, a plausible explanation was surmised. In working with the adult survivors, the more expressive techniques serve to help the clients to get in touch with their feelings and to express them. A behavioral approach, such as practicing a new behavior, and/or a cognitive approach, such as reframing or insight therapy, may then be used to change destructive behaviors and faulty thinking. It is also possible that a therapist’s initial orientation to therapy may differ in the approach that the therapist subsequently uses, based on personal (the therapist) characteristics, successful experience in therapy with clients, and/or exposure to new techniques via association with other therapists, continuing education and client-generated suggestions.
Phase 1 Pilot Study Interviews

Appendix E contains the interview records for the pilot study. Verbatim dialogues were summarized according to target questions and the participants’ responses. Key words and phrases were extracted from the responses and placed in the third column. This was done to assist in identifying essential concepts. An educational researcher was also asked to review the pilot responses, minus the concepts identified by this researcher. A graduate student in statistics provided a third review of the pilot responses. Both were then asked to extract key words and phrases. A discussion followed among the two researchers and graduate student until agreement was reached on key concepts. These key concepts were used in developing both the survey and interview schedule. Subsequently, the pilot subjects were asked to review the survey instrument and list of interview questions to verify that the phenomenon under investigation was adequately captured.

Responses to the six questions follow.

1. How did you come to use play therapy techniques with adult survivors?

Three participants listed experience with the Trauma Model, and 1 respondent reported it was the experience gained while working at a child and adolescent residential facility. Anger management was reported by 2 therapists, as was the use of art therapy as a means of expressing feelings. The importance of establishing a therapeutic relationship, especially trust in the relationship, was highlighted by 2 of the therapists. One therapist indicated family therapy and the association of play with family therapy. Another therapist discussed the interruption in developmental growth and the importance of having a representative object, which helps the client in the process of building trust and the movement toward object permanence.
2. How do you determine which clients you will use play therapy techniques with? To this question, responses were diverse, but the main theme of client readiness emerged. The ability to get in touch with feelings and express them was the primary rationale. Depending on the age of abuse, age-appropriate experiential interventions were employed.

3. Would you describe a session where you used play therapy techniques? One participant told the story of a client who was depressed and angry, but could not express her feelings. The therapist took the client into the gym, where the client began to throw clay balls. During the processing of the intervention, the client revealed anger at her mother for not protecting her. She was able to verbalize the hurt that she felt in not being loved by her father.

Another therapist related a session in which the client stated that she wanted to rip the therapist's office apart. The therapist took the client into the playroom, where the client made Play-Doh balls and threw them at a Play-Doh abuser. Further elaboration was obtained during the therapist's response to Question 3, adding that at the end of the session, the client made an Amazon clay image, a metaphorical image for her strength. With clients who were abused at a pre-verbal stage, the therapist reported using coloring pictures. A third example given by this therapist, of therapy used with an adult survivor, was assigning the client to buy herself a Christmas present for a child ages 5 and 12, the ages when the client was abused. The client bought a doll and brought it to the next therapy session. The therapist used this intervention so the client would experience giving herself permission to take care of herself.
The participant, who is an art therapist, asked her angry client to draw the anger that she said she felt. The projected drawing then became the focus of a discussion, which opened up painful feelings from the past, including the source of her anger and how it affected her life. Subsequent sessions focused on resolving the anger. This same therapist explained how she uses color to express buried feelings. For example, the therapist might ask the client his or her favorite color. That, in turn, leads to a discussion of objects with that same color, and eventually, what events, experiences, and/or persons are associated with those items. Issues arising during the discussion then become the focus of therapy.

The participant, who has had several years of experience in working with adolescents, stated that he presents his adult clients with problem-solving tasks. As an example, the therapist referred to a symbolic table with wheels. The client imagines him or herself on the table and must get across the room. The wheels are the things or people that help the client accomplish the task. Touching the floor represents something harmful or painful. The client is asked what he or she wants to get rid of and what is needed to accomplish the task.

One participant reported eating with the client. This might be a picnic or sack lunch, as they sit on the floor. The therapist might tell a story, while the client is rocking in a rocking chair. A blanket is offered for warmth. Transference through the objects (blanket or pillow) is used to process the experience.

The participant who initially denied the use of play therapy told of a session with a resistant client. The therapist focused on the therapeutic relationship as a means of addressing the client’s avoidance. This therapist used a warm afghan,
which the client chose to wrap up in for physical and emotional warmth. The therapist pointed out a candy dish, and stated openly that she believed her office provided a warm atmosphere, which assisted in disclosure and healing. The client in this scenario was able to open up and discuss how she had been hurt in past relationships.

While some of the examples of using play therapy may not be thought of as play per se, it is important to remember that these responses were how the participants in the pilot study initially perceived the use of play therapy.

4. Why did you choose to use this technique at this time? Repeatedly, the responses were: to help the client express his or her feelings. Age of abuse and the corresponding developmental stage was a determining factor for two therapists. Lack of trust and the importance of the therapeutic relationship were other reasons for choosing the particular interventions. Awareness and used as a medium for healing the past were the final reasons given.

5. Are there other techniques that you frequently use? Family sculpting, movement therapy, hypnotherapy, journaling, anger release interventions, such as breaking clay pots and/or screaming, coloring, games, art, therapy dolls, puzzles, which are symbolic for putting one’s life back together, role playing, sand tray, and psychodrama were responses given to this question. The participant who used therapy dolls was the one who initially denied the use of play therapy. This therapist is currently working exclusively with a college population.

6. Is there anything else that you would care to share with me about play therapy with adult survivors? Several summary statements were offered. One
therapist spoke to the concept of trauma as being physical, sexual, verbal, or emotional. He added war and abandonment were also traumatic. The use of these play therapy techniques can wipe away two or three sessions (compared to talk therapy), according to this trauma therapist. The importance of a safe environment was emphasized. A second therapist agreed that play therapy could lead to a quicker recovery, as normal development had been arrested, and through the use of play therapy, the client can go back and re-work the painful past. Children who are being abused strive to cope as best they know how as a means of survival. These coping mechanisms are frequently ineffective. Clients, stated this participant, can be taught healthier, effective coping skills. The ability to have balance in one's life and to honor one's emotions was a goal of one therapist. A spiritual component echoed the concept of mind, body, and spirit balance. Play therapy is, according to one therapist, the ability to be vulnerable, to cry with the client, and it was suggested that therapists need to do their own work.

**Phase 2 Data Analysis**

As previously stated, pilot study participants were practicing therapists and were asked to complete the online survey after the revisions were made. Thus, the descriptive data analysis that follows contains the data from all participants in Phase 2.

**Demographic Data**

One hundred and ten potential participants responded to the initial email invitation to participate, disqualifying themselves because they either did not work with adult clients or were no longer seeing clients. Though their comments were
encouraging for the study, it is impossible to know if they would use play therapy with adult clients or not. Thirty-seven subjects did complete the online survey. In response to the survey Question 1, which asked if the participant used play or experiential therapy with adult survivors of childhood sexual abuse, 24, 64.9%, answered yes that they used play therapy with adult survivors. Thirteen, 35.1%, responded that they did not use play therapy with adult survivors. Although caution must be exercised in making any speculations based on the small number, it is encouraging that 64.9% of the sample expressed using play therapy with adult survivors and that those who disqualified themselves for the study expressed interest and encouragement in the topic.

Percentage of Practice

When asked what percentage of the participant's practice was comprised of adult survivors, 8 participants responded that 25% or less of their clients were adult survivors. Two subjects said at least 50% were adult survivors, 3 subjects stated 75% were adult survivors, and 1 participant claimed 100% of her practice consisted of adult survivors. There were 23 participants who completed the online survey, but did not answer this particular question. Because only 14 of the 37 participants answered this question, conclusions are limited in their significance. A larger sample would have provided a more accurate description of the percentage of adult survivor clients seen by this sample therapist population (see Table 1).
Table 1

*Percentage of Practice With Adult Survivors of Childhood Sexual Abuse*

<table>
<thead>
<tr>
<th>Percentage of Practice</th>
<th>Frequency</th>
<th>Percentage of Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 or less</td>
<td>8</td>
<td>21.6</td>
</tr>
<tr>
<td>75</td>
<td>3</td>
<td>8.1</td>
</tr>
<tr>
<td>50</td>
<td>2</td>
<td>5.4</td>
</tr>
<tr>
<td>100</td>
<td>1</td>
<td>2.7</td>
</tr>
<tr>
<td>Total responding</td>
<td>14</td>
<td>37.8</td>
</tr>
<tr>
<td>Missing cases</td>
<td>23</td>
<td>62.2</td>
</tr>
<tr>
<td>Totals</td>
<td>37</td>
<td>100.0</td>
</tr>
</tbody>
</table>

**Degrees**

When the participants were asked to designate their highest degree, 13 stated they had earned a doctoral degree, either Doctor of Philosophy (PhD) or Doctor of Education (EdD) and 28 held master’s degrees. The most frequently occurring degrees were the Master of Social Work (MSW) = 13 and the Master of Arts (MA) = 13. Two participants held Master of Science (MS) degrees and 1 participant held a Master of Education (MEd). Five participants held two graduate degrees. Obtaining a graduate degree requires several years more of advanced specialty study and clinical training. While requirements may vary by institution, common curricular threads reflect content specific to the discipline for which the degree is intended to prepare the student, scholarly activity, including, but not limited to research methodology, ethical and legal practice, and courses in clinical practice areas. Each state’s regulatory body for the chosen profession governs licensure and
credentialing. In general, degree-granting institutions incorporate professional licensure and credentialing requirements into their curriculum. Table 2 lists degrees.

Table 2

<table>
<thead>
<tr>
<th>Degree</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSW</td>
<td>13</td>
<td>35.1</td>
</tr>
<tr>
<td>MA</td>
<td>13</td>
<td>35.1</td>
</tr>
<tr>
<td>PhD</td>
<td>10</td>
<td>27.0</td>
</tr>
<tr>
<td>EdD</td>
<td>3</td>
<td>8.1</td>
</tr>
<tr>
<td>MS</td>
<td>2</td>
<td>5.4</td>
</tr>
<tr>
<td>MEd</td>
<td>1</td>
<td>2.7</td>
</tr>
</tbody>
</table>

Certifications

When the participants were asked to list their certifications in the area of counseling, more than one certification could be checked off for each participant. The mode for the sample was Registered Play Therapy – Supervisor (RPT-S) = 22. This finding was expected since the pool of potential participants included therapists listed as being RPT-S certified in the Association for Play Therapy Annual Directory (2003). Licensed Clinical Social Workers (LCSW) was the next most frequently selected certification selected by the participants = 9. There were 8 participants who selected Licensed Psychologist (LP) and 2 who selected Limited License Psychologist (LLP). Seven participants selected Licensed Marriage Family Therapist (LMFT). Five participants selected Licensed Professional Counselor (LPC) and 4 selected Clinical Social Worker (CSW). While, the LCSW and CSW could be
merged as one category, they are separated here, because of participant-selected designation. Under “other,” participants listed: (a) Academy of Certified Social Workers (ACSW) = 2 (this designation might be included with the LCSW and CSW as well, but is listed, because of participant choice), (b) Licensed Specialist in School Psychology (LSSP), (c) Licensed Mental Health Counselor (LMHC) = 2, (d) Nationally Certified School Psychologist (NCSP), (e) registered nurse (RN), (f), National Certified Counselor (NCC), (g) National Association of Social Workers (NASW), which is actually an association membership, (h) Filial therapist, (i) highest level psychologist in Pennsylvania, not called LP, (j) Certified in Psychodrama, and (k) worked with Dr. Ross.

Once again, multiple selections occurred in response to this question, survey Question 4. See Table 3 for the breakdown of these certifications.

Table 3

<table>
<thead>
<tr>
<th>Therapist Characteristic</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Play Therapy – Supervisor</td>
<td>22</td>
<td>59.5</td>
</tr>
<tr>
<td>Licensed Clinical Social Worker</td>
<td>9</td>
<td>24.3</td>
</tr>
<tr>
<td>Licensed Psychologist</td>
<td>8</td>
<td>21.6</td>
</tr>
<tr>
<td>Licensed Marriage Family Therapist</td>
<td>7</td>
<td>18.9</td>
</tr>
<tr>
<td>Licensed Professional Counselor</td>
<td>5</td>
<td>13.5</td>
</tr>
<tr>
<td>Clinical Social Worker</td>
<td>4</td>
<td>10.8</td>
</tr>
<tr>
<td>Limited Licensed Psychologist</td>
<td>2</td>
<td>5.4</td>
</tr>
</tbody>
</table>

Theoretical Orientation

Results from Question 5 of the survey suggested that the theoretical orientations among the participants in this study varied considerably. Some participants selected
more than one category. The most predominant orientation was cognitive therapy = 15. Cognitive therapy is based on the premise that it is the perception of events that causes problems (Beck, 1995). The goal of therapy is to change irrational beliefs, faulty reasoning, and negative self-statements. Seven participants selected both cognitive and behavioral orientation, signifying that they use cognitive behavioral interventions. Cognitive behavioral therapy is an empirically based, goal-oriented approach that involves active and collaborative efforts on both the therapist's and client's behalf. The therapist serves as a teacher in helping the client learn new, more-effective coping skills. The therapist assesses the client's behavior, thoughts, and feelings. Together, they develop a plan to apply these new learned skills in daily life (Stuart & Laraia, 2005).

Three therapists used the Trauma Model, and 3 either the Systems or Family Systems theory. The Trauma Model, as conceived by Dr. Colin Ross (2000), has its roots in cognitive behavioral techniques and strategies with the greatest emphasis on cognitive restructuring. Elements of expressive therapy and systems theory are interwoven in a complex model that values the client as a person, worthy of respect and dignity. Life is meaningful, and negative concepts of self and the future are eliminated as the client recovers and grows. Systems or Family Systems theory views the family as an open system, wherein members interact with one another and others. Emphasis is on improving interaction among members. Strategic and Systemic Family Therapy focuses on problem resolution through planned change (Nichols & Schwartz, 1995).

Each of the following were listed at least once: (a) Self Relations therapy (Stephen Gilligan), (b) Psychodynamic interventions, (c) Adlerian, (d) Object-
relations Attachment, (e) Christian Emotionally Focused Therapy, (f) Experiential, (g) Prescriptive, (h) Narrative Emotionally Focused Therapy, (i) Psychodrama, and (j) Art Therapy. Gilligan's Self Relations therapy is based on the work of Milton Erickson, the hypnotherapist. Three main differences exist. They are: (a) teaching the client to relate to his unconscious in a personal way; (b) helping the client to reconnect to the center of feeling within the unconscious; and (c) staying in the here and now (Gilligan, 1997).

Alfred Adler, breaking away from Freud's Psychoanalytic theory, postulated that the motivating force behind behavior was the striving for perfection. Adler's Individual Psychology embodied a holism in its view of a person's life style. He believed individuals move towards goals, called teleology. Along the way, one must learn to overcome inferiorities. Adlerian theory includes the effect of birth order on the development of the child. An Adlerian therapist is non-authoritarian and encourages the client to engage in the therapeutic relationship, which is later transferred to others (Boeree, 1997). Object-relations Attachment is a form of psychoanalysis that focuses on relationships and the attachment to those relationships. In this theory, the infant moves from a state of dependence on caregivers (objects) through a point in which the infant is able to differentiate the self from the objects. To facilitate this passage, transitional objects are employed, such as the thumb, teddy bear, and so forth (Fonda, 1995).

Experiential therapy is broadly defined to include creative arts and activities that provide an expression through symbolism. Included are dance, movement therapy, art, and role playing (Felber, 2001). Prescriptive therapy utilizes a customized treatment approach, which may involve eclectic interventions (Norcross, 1993).
Psychodrama, founded by Jacob Moreno (1946), assists the client in portraying him or herself in expressing problems or issues. Feedback is given to help the client gain insight, grow, and resolve problems (Malchiodi, 2005). According to Malchiodi (2005), Art Therapy has a broad definition, but at its core is the medium of communication and self-expression. Particularly pertinent to the use with adult survivors is the facilitation of expressing experiences too painful to verbalize.

Table 4 lists the frequency of therapists’ theoretical orientation.

Table 4

*Theoretical Orientation of Therapists*

<table>
<thead>
<tr>
<th>Theoretical Orientation</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive</td>
<td>15</td>
<td>40.5</td>
</tr>
<tr>
<td>Humanistic</td>
<td>8</td>
<td>21.6</td>
</tr>
<tr>
<td>Cognitive Behavioral</td>
<td>7</td>
<td>18.9</td>
</tr>
<tr>
<td>Gestalt</td>
<td>5</td>
<td>13.5</td>
</tr>
<tr>
<td>Psychoanalytic</td>
<td>4</td>
<td>10.8</td>
</tr>
<tr>
<td>Systems/Family Systems</td>
<td>3</td>
<td>8.1</td>
</tr>
<tr>
<td>Trauma Model</td>
<td>3</td>
<td>8.1</td>
</tr>
</tbody>
</table>

**Developmental Theories**

Question 6 of the survey asked participants to identify the developmental theory that most influenced their practices. See chapter 1 for definitions of theories. The most frequently selected developmental theory was Erikson’s Psychosocial theory of development = 21. Mahler’s Object-relations was selected 14 times. Sullivan’s Interpersonal and Piaget’s Cognitive theory were each selected seven times. Freud’s Psychoanalytic and Kohlberg’s Moral theories were selected four and two times, respectively. Other developmental theories influencing practice included Trauma...
Model = 2, Adlerian = 2, Attachment theory according to Bowlby = 2, Family development = 1, Lifespan development = 1, and Art therapy = 1. Table 5 lists the developmental theories and their frequency of selection. Some participants selected more than one developmental theory.

Table 5

*Developmental Theories Influencing Practice*

<table>
<thead>
<tr>
<th>Theory</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosocial (Erikson)</td>
<td>21</td>
<td>56.8</td>
</tr>
<tr>
<td>Object-relations (Mahler)</td>
<td>14</td>
<td>37.8</td>
</tr>
<tr>
<td>Interpersonal (Sullivan)</td>
<td>7</td>
<td>18.9</td>
</tr>
<tr>
<td>Cognitive (Piaget)</td>
<td>7</td>
<td>18.9</td>
</tr>
<tr>
<td>Psychoanalytic (Freud)</td>
<td>4</td>
<td>10.8</td>
</tr>
<tr>
<td>Moral (Kohlberg)</td>
<td>2</td>
<td>5.4</td>
</tr>
</tbody>
</table>

When the participants were asked to identify their overall approach to therapy, an eclectic approach was the most frequently selected approach = 16. The experiential and expressive approaches were each selected eight times.

Experiential approach was described by Felber (2001) as the expression of feelings, emotions, and thoughts through creative arts and activities that utilize symbolism to communicate their meaning. Malchiodi (2005) defined expressive therapy as the therapeutic use of arts and play to facilitate change, communication, problem solving, and skill development in interpersonal relationships. Both experiential and expressive approaches utilize some of the same techniques. This raises the need for clear and universal terminology in future research on play therapy with adult survivors. It is the participant’s choices, however, that are reported here.
The cognitive approach was selected six times; interpersonal, five times; behavioral, three times; and psychoanalytic, twice. The Trauma Model was listed four times under the "other" category. Additional write-ins were psychodynamic, integrated, object-relations, attachment, narrative, psychodrama, joy, and art. Table 6 lists the various approaches to therapy and the frequency of their selection.

Table 6

*Approaches to Therapy*

<table>
<thead>
<tr>
<th>Approaches to Therapy</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eclectic</td>
<td>16</td>
<td>43.2</td>
</tr>
<tr>
<td>Experiential</td>
<td>8</td>
<td>21.6</td>
</tr>
<tr>
<td>Expressive</td>
<td>8</td>
<td>21.6</td>
</tr>
<tr>
<td>Cognitive</td>
<td>6</td>
<td>16.2</td>
</tr>
<tr>
<td>Interpersonal</td>
<td>5</td>
<td>13.5</td>
</tr>
<tr>
<td>Trauma theory</td>
<td>4</td>
<td>10.8</td>
</tr>
<tr>
<td>Behavioral</td>
<td>3</td>
<td>8.1</td>
</tr>
<tr>
<td>Psychoanalytic</td>
<td>2</td>
<td>5.4</td>
</tr>
</tbody>
</table>

*Presenting Problems of Clients With Whom Play Therapy Is Used*

When the participants were asked to select the most frequently presenting problems of adults with whom they used play therapy, the sample made multiple selections. The most frequently selected presenting problem was depression = 21, followed by Post Traumatic Stress Disorder (PTSD) = 20, victims of sexual abuse = 17, and anxiety = 15. Dissociative Identity Disorder (DID) was selected 10 times. Substance abuse = 6 and eating disorders = 5 were selected less frequently. Under "other" categories, the following five write-ins were listed: (a) adjustment disorder; (b) boundary, empowerment, and phase of life issues; (c) coping with anger.
projected at the parent for not protecting the abused child; (d) relationship difficulties; and (e) trauma victims. See Table 7 for the list of presenting problems identified.

Table 7

*Presenting Problems of Adult Clients With Whom Play Therapy Is Used*

<table>
<thead>
<tr>
<th>Presenting Problem</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>21</td>
<td>56.8</td>
</tr>
<tr>
<td>Post Traumatic Stress Disorder</td>
<td>20</td>
<td>54.1</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>17</td>
<td>45.9</td>
</tr>
<tr>
<td>Anxiety</td>
<td>15</td>
<td>40.5</td>
</tr>
<tr>
<td>Dissociative Identity Disorder</td>
<td>10</td>
<td>27.0</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>6</td>
<td>16.2</td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>5</td>
<td>13.5</td>
</tr>
</tbody>
</table>

**Research Questions**

**Research Question 1**

The first research question asked, “To what extent is play therapy used by therapists who work with adult survivors of childhood sexual abuse?” Question 1 of the online survey was formulated to answer this first research question. Question 1 asked if the participant used play or experiential therapy with adult survivors of childhood sexual abuse. It was a forced choice yes or no response. Twenty-four of the 37 participants, 64.9%, answered yes that they used play therapy with adult survivors. Thirteen of the 37 participants, 35.1%, responded that they did not use play therapy with adult survivors. While the 110 invited participants who disqualified themselves from the study expressed interest and encouragement in the topic, they cannot be counted as therapists who use play therapy with adult survivors. Their positive support is, nevertheless, appreciated.
Because of the small sample size, caution is herein exercised in generalizing survey data to answer the question, “To what extent is play therapy used with adult survivors of childhood sexual abuse?” What is apparent is that interest is there, and more importantly, play therapy is being used to treat adult survivors of CSA.

Research Question 2

The second research question in this study asked, “What techniques are commonly used by therapists who work with adult survivors of childhood sexual abuse?” It is here noted that among the therapists in this study, a wide range of techniques were identified. Of those listed, one, journaling, is not generally considered a play therapy technique, although it is considered a well-known technique used with adult survivors of childhood abuse.

Quantitative data from the survey and qualitative narratives richly described a variety of techniques that are being used by therapists who treat adult survivors. First, a compilation of these techniques was obtained from the online survey. Two respondents did not select any techniques. One participant selected only one technique. The remaining 34 selected more than one technique. An identifiable pattern of selection could not be determined, however. The three most frequently selected techniques were journaling = 25, sand tray = 23, and art = 22. While journaling is a technique common to cognitive and other treatment modalities, it is a technique that may be used with children and adolescents, as well as adult survivors. It allows the client to privately explore thoughts and feelings and to come to terms with stressful events (Purcell, 2001). Anger management and imagery were each selected 20 times. Role-play = 18 and humor = 15 were selected 48.6% and 40.5% of
the time, respectively. Therapeutic games were selected nine times. Physical activity, psychodrama, and puppetry were selected eight times each. Seven subjects distinguished finger painting from the use of art in general. Less frequently selected were music = 4 and dance = 3. Other techniques included hypnotherapy, reframing the situation, insight therapy, problem-solving tasks, movement therapy, and selected videos. Table 8 lists the various techniques identified in descending order of frequency.

Table 8

Techniques Used With Adult Survivors

<table>
<thead>
<tr>
<th>Techniques</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Journaling</td>
<td>25</td>
<td>67.6</td>
</tr>
<tr>
<td>Sand Tray</td>
<td>23</td>
<td>62.2</td>
</tr>
<tr>
<td>Art</td>
<td>22</td>
<td>59.5</td>
</tr>
<tr>
<td>Anger Management</td>
<td>20</td>
<td>54.1</td>
</tr>
<tr>
<td>Imagery</td>
<td>20</td>
<td>54.1</td>
</tr>
<tr>
<td>Role-play</td>
<td>18</td>
<td>48.6</td>
</tr>
<tr>
<td>Humor</td>
<td>15</td>
<td>40.5</td>
</tr>
<tr>
<td>Therapeutic Games</td>
<td>9</td>
<td>24.3</td>
</tr>
<tr>
<td>Physical Activity</td>
<td>8</td>
<td>21.6</td>
</tr>
<tr>
<td>Psychodrama</td>
<td>8</td>
<td>21.6</td>
</tr>
<tr>
<td>Puppetry</td>
<td>8</td>
<td>21.6</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>21.6</td>
</tr>
<tr>
<td>Finger Painting</td>
<td>7</td>
<td>18.9</td>
</tr>
<tr>
<td>Music</td>
<td>4</td>
<td>10.8</td>
</tr>
<tr>
<td>Dance</td>
<td>3</td>
<td>8.1</td>
</tr>
</tbody>
</table>

Research Question 3

Research Question 3 asked, “How do therapists who use play therapy with adult survivors of childhood sexual abuse rate the effectiveness of play therapy techniques?” A 5-point Likert scale was presented on the study survey. Anchors
were 1 = Ineffective, 3 = Moderately Effective, and 5 = Very Effective. The mode and median effectiveness were both 5 = Very Effective. Eighteen therapists selected Very Effective; 12 selected 4 on the scale; 4 subjects selected Moderately Effective; 1 therapist selected 2 on the scale. No one selected Ineffective. There were 2 missing cases. In sum, 81% of the participants selected a 4 or 5, suggesting a more than moderate effectiveness of the play therapy techniques. Table 9 provides this breakdown.

Table 9

<table>
<thead>
<tr>
<th>Effectiveness Rating</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 = Very Effective</td>
<td>18</td>
<td>48.6</td>
</tr>
<tr>
<td>4</td>
<td>12</td>
<td>32.4</td>
</tr>
<tr>
<td>3 = Moderately Effective</td>
<td>4</td>
<td>10.8</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>2.7</td>
</tr>
<tr>
<td>1 = Ineffective</td>
<td>0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Correlation Coefficient

A correlation coefficient was calculated, using the Pearson product-moment correlation coefficient formula to evaluate the relationship between the percentage of practice with adult survivors and the therapists' perceived effectiveness of using play therapy techniques. It was postulated that those who used play therapy techniques with adult survivors more frequently would rate effectiveness higher. There was, however, little variance among participants in this sample. Thus, results from this data demonstrated a low correlation, with $r = 0.28$. According to Munro (2001), a correlation of 0.26 to 0.49 is considered a low correlation. The variance shared between the two variables was 7.89%. Thus, 92.11% of the variance is unaccounted.
for. The finding is not significant at $p = 0.05$. Because the sample was small ($n = 35$), great caution is exercised in generalizing this finding to the larger population. It offers, however, a potential area for further exploration.

$t$-Test Analysis

To evaluate the differences in perceived effectiveness of play therapy with adult survivors between therapists with a doctoral degree and those with a master’s degree, an independent samples $t$ test with equal variances was calculated. For those who held both a doctoral and a master’s degree, the highest degree, a doctorate, was used in determining assignment to the two groups. The independent samples $t$-test analysis indicates that 11 therapists with a doctoral degree had a mean of 4.36, with a standard deviation of 1.02 in their effectiveness rating of play therapy with adult survivors; and 24 therapists with a master’s degree had a mean of 4.33, with a standard deviation of 0.70 in their effectiveness rating of play therapy with adult survivors. The means did not differ significantly at the $p < 0.05$ level ($p = 0.919$).

Levene’s test for Equality of Variances indicates variances for doctoral- and master’s-prepared therapists do not differ significantly from each other ($p = 0.198$), allowing the $t$-test for equal variances to be calculated. See Table 10, which lists the group means for each group and the $t$-test results.

Because participants were asked only to identify presenting problems of their clients, their general approach, and the play therapy techniques that they used with adult survivors, additional correlations between approach and presenting problem or presenting problem and technique(s) used could not be determined.
Table 10

*t Test for Group Means*

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean</th>
<th>SD</th>
<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctoral-prepared</td>
<td>4.36</td>
<td>1.02</td>
<td>.102</td>
<td>33</td>
<td>.919</td>
</tr>
<tr>
<td>Master’s-prepared</td>
<td>4.33</td>
<td>0.70</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Phase 3 Qualitative Analysis and Principles of Grounded Theory

When little is known on a topic, an exploratory approach is most appropriate; thus a qualitative methodology, utilizing in-depth interviews provided data rich in social processes. Analysis of the 21 interviews served to build a model for practice with adult survivors of CSA.

According to Stern (as cited in Streubert Speziale & Carpenter, 2003), there are five basic principles in the development of Grounded Theory. They are:

1. The conceptual model is generated from the data.
2. The researcher looks for dominant processes in the emerging data.
3. All data are compared with all other data.
4. Data collection may be modified, based on the developing model.
5. Data are coded, categorized, and conceptualized as they are obtained.

Responses to each of the six interview questions follow. Appendix E contains the summarized responses of each participant for the six questions. Final analysis of the interviews was based on the Theme Analysis for Word-Rich Data (Cooper, 2003) process. See Appendix D for this process.
Phase 3 Interview Questions

Interview Question 1

In Interview Question 1, participants were asked, “How did you come to use play therapy techniques with adult survivors?” To this question, five categories emerged. The first category was exposure at work.

**Interviewee 2004-001**: Currently working in the Trauma Program at Forest View Psychiatric Hospital, in Grand Rapids, Michigan, this therapist learned techniques from Dr. Ross, director of the program and his associate. By working with other therapists in the program, this therapist adopted anger management techniques and art therapy techniques.

**Interviewee 2004-003**: This therapist is also employed in a Trauma program as an art therapist.

**Interviewee 2004-005**: This therapist attributed his use of play therapy techniques with adult survivors to his practicum experience at Andrews University and subsequent employment at Eagle Village, a live-in facility for troubled youth. “They called them interventions.”

**Interviewee 2004-006**: A therapist, who sees clients at Forest View Hospital, explained that “the child’s developmental stage stopped at the time of abuse. I give them an object (talisman) to represent where they were when they were abused. The object serves as a ground, as they move towards object permanence.” This psychologist referred to the works of Drs. Ross and Whitfield and to the theory of object relations.

**Interviewee 2004-007**: “I started doing psychodrama with a patient in the
psychiatric unit; then, I was supposed to do psychodrama with the general adult population.” Finally, “I began to use it with folks who had been traumatized.”

**Interviewee 2004-008:** “I only had one room and it was a playroom,” explained this therapist. “I did sand tray. It was natural. You almost couldn’t not play.” This therapist went on to explain, “If you have the material in the room, it doesn’t matter how old the person is, they’re going to go to it.”

The second category as to how they came to use play therapy with adult survivors was in their previous work with children and adolescents who had been abused.

**Interviewee 2004-009:** Originally working with children, this therapist applied techniques that she used with children to adult clients.

**Interviewee 2004-010:** This participant began using play therapy with children; and later started using it with adults. After attending several workshops on sand tray, including working with adults, she found that “for adults who have difficulty accessing their feelings, it seems to work pretty well.”

A therapist who works with children and their families (filial therapy) explained how she came to use play therapy with adults.

**Interviewee 2004-012:** “Because I work mostly with kids and their families, I have always done most of my therapy in the playroom” was this therapist’s response. She explained how early in her career, she was working with an adult survivor, with whom she had previously worked with while doing Filial therapy with the client’s son. During an intense session, the client began to regress and dissociate. “Being at a loss as to what to do, I began using toys to help her feel safe and to help her with her feelings. It worked well and I began using more play with this population.”
Another therapist echoed this transition from working with children and their families to applying play therapy to working with adult clients.

**Interviewee 2004-019:** When this therapist knows that a parent has been a victim, she will try to engage them in play with their child. She explains to the parent the purpose of what she is doing and coaches the parent as he or she plays with his or her child. “The parents are getting healing [vicariously] out of that.”

The third category as to how they came to use play therapy with adult survivors was a *background in art and/or expressive therapy and the realization that feelings could be expressed through the media of art and other expressive therapies.*

**Interviewee 2004-003:** Through teaching art classes to students of all ages, this respondent realized the power of art in revealing inner thoughts, fears, and feelings. A friend suggested that she go back to school to be an art therapist. She did and is now employed as an art therapist in a Trauma program.

**Interviewee 2004-007:** A certified psychodramatist, this therapist uses psychodrama with traumatized patients.

**Interviewee 2004-009:** With a background in art therapy, this therapist began to see applications for play therapy. “All the things that I would use art for, it made sense to think about play therapy.” Initially sharing an office with a therapist who used sand tray, she learned the basic techniques of sand tray. She applied techniques to adults that she used with children. She has animals in her office and would ask the client to pick an animal that represents family members. The animals were used to communicate what the client wanted to say to the family members.

**Interviewee 2004-011:** “It just seemed natural” to this participant. She went on to explain, “Talk therapy allows people to stay in their head, where expressive
therapy when you’re using more than one sense and one way in which to discuss and process what’s happened is more affective.” She then added, “I think the biological and chemistry of trauma lends itself to that. It’s a more holistic approach and I think it enables people to be able to deal with their thoughts as well as their experiences.”

**Interviewee 2004-013:** As a registered art therapist, this therapist stated that “that’s [art therapy] the most effective form of therapy with adult survivors.”

**Interviewee 2004-018:** “I really love play therapy. I went to a conference and the speaker explained how posttraumatic play therapy with kids is like flashbacks for adults. So I said, why don’t we take the flashbacks out of the grownups heads and have them do play therapy.” This therapist had figured out that she could have her clients “show me with toys or art what a flashback looks like.”

**Interviewee 2004-021:** A music therapist, this participant uses music to help clients get in touch with their feelings. Happy and sad memories may be generated.

The fourth category as to how they came to use play therapy with adult survivors was *working with a particular client or type of clients.*

**Interviewee 2004-004:** This therapist’s introduction to play therapy began when she was working with an angry adult client. Having difficulty helping the client deal with her anger, she took the client into the playroom and had the client make a Play-Doh person to represent her abuser. The client threw balls at the representative abuser. It worked, and so this therapist began to use other play therapy techniques with other clients. The therapist added, “Play is something that adult survivors haven’t gotten.”

**Interviewee 2004-017:** This therapist worked with several adult clients with DID. She uses stories in therapy to reach child alters.
A fifth category as to how they came to use play therapy with adult survivors that emerged was the use of play therapy with adult clients when other more traditional therapies had failed or an impasse in therapy occurred.

**Interviewee 2004-014:** “The sand tray is in my office, so they have been curious about that.” When the client gets ‘stuck’, this therapist asks them to “put it in the sand.”

**Interviewee 2004-016:** “Well, I had people in therapy that weren’t making progress. [I] started with art therapy; then I used kitchen items, sand tray, and Silly Putty. A lot of people need help going back to that time of abuse.” This participant went on to explain that she had a play room and if the client gets ‘stuck’, she will take them into the play room.

**Interviewee 2004-020:** This participant is a play therapist and often receives referrals from other therapists when their adult clients are ‘stuck’ in therapy. “The person [client] walks in knowing that they are going to be offered or invited to do things other than sit and talk.”

In summation, when asked how did you come to use play therapy with adult survivors, many respondents stated that they had learned the power of play by observing other therapists using it. For example, they may have been exposed to the use of sand tray and other expressive/experiential therapies because they worked with another therapist or in an agency where these modalities were used. Or, it may have been a formal educational process.

One reflective therapist (Interviewee 2004-011) explained the power of play in that “talk therapy allows the person to stay in his/her head; whereas, expressive therapy, especially when more than one sense is used, facilitates more affective
processing.” When a client reaches a point in therapy where it is too painful to discuss the past, it was suggested that expressive or play therapy may assist in moving the client forward out of that dark hole. Clients who regress or dissociate may find comfort in a setting where play is encouraged. Play, as one therapist (Interviewee 2004-017) put it, helps those with DID validate all their egos and alters, especially the children. The client does not have to talk. It is safer for the client who has learned only too well to keep secrets. Clients can show the therapist experiences and feelings that are too painful to verbally express. Play takes the client back to the time of abuse, but in a safe environment.

One therapist (Interviewee 2004-018) specifically addressed flashbacks, saying that she asks clients to show her with toys or art what a flashback looks like. The therapist can see what is going on and, therefore, process the experience.

Interview Question 2

In Interview Question 2, participants were asked, “How do you determine which clients you will use play therapy techniques with?” Four themes were identified in response to this question. The first theme was that the client must be ‘ready’. Being ‘ready’ means that the client and therapist have developed a therapeutic relationship, in which the client feels safe to express feelings and emotions and is willing to try interventions aimed at these expressions.

Interviewee 2004-001: “The client must be ready. I do Trauma consultations. If I have a client who is stuck in depression, I go to the anger. I try to get them in touch with what their body is feeling.” This participant went on to give an example. “If they can’t express themselves, we might go into the gym. I will get them started
by throwing clay balls at the wall. Then, I have them talk about what they are feeling.”

**Interviewee 2004-009:** “Sometimes they express an interest in play or art, or if I feel that there is dissociation and a lot of memory blockage, I would use the sand tray.” The therapist explained, “I find that it [sand tray] allows expression of dissociated parts or dissociated trauma.”

**Interviewee 2004-012:** “Because I see play and humor as essential and powerful coping/adapting mechanisms, I now find ways to use them with all clients, unless it simply does not fit their problem.” This therapist further explained, “The key issues for using play therapy with adults are: (a) the nature of my relationship with them, and (b) the timing. There must be decent rapport and trust before I do much play therapy, although, I use humor from the start.” She cautioned, “Play therapy can be powerful, so the timing must be considered so the client’s own defenses aren’t circumvented, and the client feels ready to handle the sometimes intense feelings brought up/released in play therapy.”

**Interviewee 2004-016:** “Their readiness and desire. It’s just a feeling.”

Clients do not necessarily come to therapy for sexual abuse treatment. When an adult client appears to be at an impasse in therapy, experiential types of interventions may bring out the abuse issues.

A subcategory of this first theme was that the client was ‘stuck’ in therapy and had reached a point in the therapeutic relationship where they felt comfortable or ‘ready’ to try an experiential approach. Two participants specifically addressed this concept of being stuck and subsequently ‘ready’ to try what might be classified as play therapy interventions. Examples are as follows.
**Interviewee 2004-005:** “Clients don’t necessarily come for sexual abuse matters. It comes out in the process. Sometimes, talking just doesn’t work and so, using experiential types of interventions does. I just use them when a client is stuck.”

**Interviewee 2004-014:** “When the client is stuck and feels powerless, then I say, let’s put it in the sand.”

The second theme that seemed to determine which clients the therapists would use play therapy techniques with was when the assessment revealed *childhood abuse* or *trauma* of some sort. Accurate assessments are essential in developing age-appropriate interventions. Age appropriate means age at the time of abuse, not their current chronological age. Thus, an adult abused as a child can transition backward to that time of abuse through sand tray, toys, or games, appropriate for a child of the abused age (O’Connor, 2000; Schaefer, 2003; Ward-Wimmer, 2003).

**Interviewee 2004-004:** “Well, if you listen to a client, they will tell you what they need. I think of it as empowerment. I’ve had clients who were abused at pre-verbal stages. I will have them color. You have the person re-work those early developmental stages.”

**Interviewee 2004-006:** “One therapy does not fit all for adults with sexual abuse. If they are dissociating, you have to design your therapy to the level that they are at.”

**Interviewee 2004-008:** This therapist had two separate rooms, one with a sand tray and toys. She explained how she would invite an adult client with DID to “have the kids [alters] tell their story.”

**Interventions 2004-019:** This therapist looks for indicators of early trauma in her assessments, especially trauma that occurred from birth to ages 3 or 4. “Kids of"
that age do not have the kind of brain development to put that kind of trauma into words.” She therefore uses more experiential techniques.

The third theme that seemed to determine which clients the therapists would use play therapy techniques with was when clinicians believed that through play therapy techniques, clients could express hidden feelings and emotions. Concern was verbalized in that revealing too much too soon can, in itself, be traumatic. The guiding principle was to be vigilant of the client’s tolerance level.

**Interviewee 2004-003:** A therapist who works as an art therapist in a Trauma program responded, “Trauma patients have issues with relationships, grief and loss, anger – we do specific things to get their body involved, like movement therapy, anger work. Even though they may feel the anger in their body, they cannot express it verbally.” As an art therapist, she is available to all the patients in the psychiatric hospital where she works, but works primarily with the trauma patients.

**Interviewee 2004-011:** “It depends on the client. I have a gentleman that was sexually abused in a cult. I had him put his feelings in the sand.” The therapist added, “I would not make someone. I offer it and if they say no, I’d say okay. You have to build the experience and their ability to tolerate what happened to them.”

**Interviewee 2004-012:** “Because I see play and humor as essential and powerful coping/adapting mechanisms, I now find ways to use them with all clients, unless it simply does not fit their problem.”

**Interviewee 2004-013:** This therapist uses play therapy with all of her clients, especially those with DID. She explained, “Art therapy with DID is very effective because it helps to clue all the different parts of the system into each other.” Play therapy, she says, “validates each of the egos and alters, especially the children. They
don't talk. They have lots of secrets.” Art therapy, in particular, helps the client to “show you things that are secretive. It’s not as threatening to show you.”

**Interviewee 2004-017:** This therapist uses play therapy techniques with clients who are “having trouble expressing themselves, even some without DID.”

The last theme that seemed to determine which clients the therapists would use play therapy techniques with was when *the therapist reported having experience with play therapy techniques* and can best be summarized by the following therapist’s statement.

**Interviewee 2004-020:** “It’s an invitation to everyone who walks into my room. It’s simply there. People are invited to the sand; invited to draw. Almost all of my clients have used sand at some point.”

**Interview Question 3**

The third Interview Question asked the participant, “Would you describe a session where you used play therapy techniques?” Several responses to Interview Question 3 had overlapping themes. Some participant responses could easily be classified as belonging to the first category, expression of feelings and emotions; the second category of nurturing and self-care; as well as the third category, processing of trauma, leading to forgiveness and acceptance.

The first predominant theme found when a therapist chose to use play therapy techniques was when they felt their *clients needed to express feelings and emotions.* Anger, powerlessness, helplessness, and shame were identified feelings and emotions.

**Interviewee 2004-001:** A depressed client was unable to express her feelings. The therapist took her into the gym and she threw clay balls at the padded wall.
When asked what she was feeling, the client expressed anger at her mother for not protecting her.

**Interviewee 2004-003:** An art therapist asked her client who had been sexually abused to draw her anger at her mother. This therapist stated that she uses color to derive associations. For example, a client chose red when asked her favorite color. The next question was ‘What are your favorite red foods?’ She replied ‘strawberries’. Why strawberries? It reminded her of walking in a field with her mother. Discussion of that ensued.

**Interviewee 2004-004:** An angry client made a clay Amazon woman, a metaphor for a powerful woman. She was able to express her previous feelings of helplessness and how she could gain control in her life.

**Interviewee 2004-008:** The client in this example buried a miniature doll in the sand tray. She had not been directed to the sand and had not previously used it. The sand tray and walls of miniatures were part of this therapist’s office. The client explained that the little doll represented a part of her that she wanted to bury.

**Interviewee 2004-009:** This therapist asked the client to choose an animal to represent how he/she felt in a relationship. The client was then asked to select another animal to represent the mother during this relationship. Next, the client selected a spiritual figure from the room. The therapist often chooses a doll to represent her. The ‘doll’ talks to the animals. The spiritual figure assists the client in expressing him or herself. Finally, the client selected an animal to represent what was going on inside of the parent. In the example that was given, the client selected a wildcat cub. This represented the parent’s own abuse, fear, and need for security. This use of imagery allowed the client to move past the negative perception of the
parent, to reach a deeper understanding of the dynamics of the relationships involved. This therapist sometimes evokes a prayer of renunciation, leading to forgiveness and acceptance of self as good.

**Interviewee 2004-010:** This therapist explained how she used sand tray, in general, rather than a specific client session to help her adult clients express feelings and issues. She first asks them to create a landscape, in the sand, using miniature objects, animals, and people. The therapist notes what miniatures are used and where they are placed in the sand. When the client has finished the landscape, the therapist asks the client to describe what she created; why she chose the objects/people that she did; and any feelings that came up during the creation. A discussion of whatever is a significant issue follows.

**Interviewee 2004-011:** This therapist described a session with a sexually molested female, who was feeling shame. The client was asked to draw shame; then represent it in the sand. Another sexually molested client had built a wall around himself, not allowing others to penetrate his barrier. In the sand tray, he placed a wall. After the session, he took the wall home with him and processed the trauma. Six months later, the client became engaged.

**Interviewee 2004-013:** As a registered art therapist, this therapist uses art therapy with all of her clients. It is an expectation, and clients are aware of this ahead of time. Either the client brings original art work with them or they work on a project in session. The therapist explained in general terms how she conducts sessions with her clients, rather than a specific session with a client. Processing the feelings and hidden meanings of the art work comprises the main emphasis of this therapist’s work. Since this therapist has an intake room and a play room, she uses the play
room to facilitate the emergence of alter egos in clients with DID. The therapist and client may actually physically go back to the intake room in a symbolic closure of the painful past.

**Interviewee 2004-015:** The use of fantasy and imagery dominates this therapist’s approach to therapy. This therapist described sessions in general, rather than a specific client session. A sand box is used to create a scene or picture of how the client is feeling at the present moment. Discussion serves to process both past experiences and feelings and present behavior and feelings.

**Interviewee 2004-016:** This therapist described a female client in her early 20s, who had gone through traditional therapy. She was a counseling student and so the therapist took her into the playroom, introducing play therapy as a treatment modality. The client immediately began to draw on the easel and talk about her feelings and past trauma.

**Interviewee 2004-017:** A session with a client with DID was described where the client was talking about responsibility. One of her alters, a teen-ager, had to take responsibility for the child alter. Art, especially drawing in the sand, helped this client express what she could not verbalize.

**Interviewee 2004-018:** This therapist told the story about a woman who had been severely abused and was having flashbacks. In the flashbacks, eyes were staring at her. The therapist had the client draw the eyes and talk to them. Then, she used a punching bag to express her anger. This therapist commented that she is more directive with adults than with children.

**Interviewee 2004-020:** This therapist placed a blank 12-piece puzzle in front of the client. The client was directed to express by drawing a scene, using words or
colors, a time when the client felt safe and happy. The client had to put herself somewhere on the paper, even if it was only a dot. The puzzle was then taken apart, while the therapist and client talked about how grief and trauma coming into a person's life causes it to fall apart. The client was given ample time to put the puzzle back together, weeping the entire time. The colors in the drawing were muted, indicating the depth of her trauma and her inability to be present and to feel faith. After 20 minutes, she was able to reconstruct the puzzle. The implication for this exercise is that one can regain/feel happiness again.

**Interviewee 2004-021:** As did a couple of other participants, this music therapist described how she conducts therapy in general terms, rather than giving a specific client example. She asks clients their favorite musical artist. The therapist then selects certain songs from that chosen artist dealing with certain emotions. Together, the therapist and client explore the songs and the emotions elicited from the music.

The second theme found when a therapist chose to use play therapy techniques was when the therapist felt the client had a need of nurturing and self-care. Problem solving is included here as a component of self-care. The next five examples of participants' responses represent the theme of nurturing and self-care (including problem-solving).

**Interviewee 2004-004:** A woman, who had been abused at ages 5 and 12, was given the assignment of buying Christmas presents for a child at those ages. She came to the next session with a doll, giggling and laughing; ultimately, giving herself permission to take care of herself.
Interviewee 2004-005: The therapist asked the client to imagine a board that was in the room as a table with wheels underneath it. The client was asked how he could get across the room without falling off (representing harm or danger). The client learned to problem-solve, as he had to identify what resources he would need.

Interviewee 2004-006: This therapist often eats with his clients. He described a picnic, where the therapist and client sat on the floor. Another example that he gave was rocking the rocking chair that the client was sitting in, while he told the client a story. He does not touch the client, but rocks the chair and gives the client a blanket or pillow for comfort.

Interviewee 2004-012: In working with a client who was having difficulty remembering details of horrific sexual and physical abuse, this therapist used Disaster Dinosaurs (VanFleet, 2001), a technique where a bendable dinosaur was given to the client. The client was instructed to put a cast on the dinosaur, because it was hurt. In applying the cast and telling the dinosaur’s story, the client was able to use the metaphor of the hurt dinosaur to recognize her own needs and rights to self-care.

Interviewee 2004-019: Coloring, dolls, sand, Play-Doh, and reading stories are some tools used by this therapist. She talked about a client, a female sex offender, who had had a horrendous abuse history. Coloring and playing with dolls were particularly impactful for her. The therapist said she tries to reach the inner child within the client and find out what they did not get, but needed. She functions, at times, in a re-parenting role. Another client, when asked what he needed, responded that he wanted someone to read to him. The therapist tape-recorded a story, which the client took home. The objective for this therapist is to get the client to connect with the wounded inner child and work on the unmet needs.
The third theme that emerged from this question of when a therapist chose to use play therapy techniques was when the therapist felt that the client needed to process the trauma, leading to forgiveness and acceptance. According to O'Connor (2000) and others (Ross, 2000; Schaefer, 2003), processing of the traumatic event(s) through play therapy techniques and subsequent discussion may lead to forgiveness of self and acceptance of self. The following examples serve to illustrate this concept.

**Interviewee 2004-001:** Through the activity of throwing clay balls, the client was able to express anger towards her mother for not protecting her. As her voice became louder and she threw the balls with greater force, the therapist helped her to process what had taken place. She was able to accept that it was not her fault.

**Interviewee 2003-009:** The response of this therapist (also noted under expression of feelings) illustrates how the use of play therapy techniques can be used to promote forgiveness and acceptance. In the scenario, the client was asked to select an animal to represent her mother and herself in the relationship. Through this exercise, the client was able to reach a deeper understanding of the dynamics in the relationship. She was then able to forgive herself and her mother and reach an acceptance of self as good.

**Interviewee 2004-013:** By processing art work, this therapist assists the client in finding closure to a painful past. The art therapy is done in a different room than is the initial intake. By going back to the intake room after processing the art therapy session, the therapist is symbolically closing the door of the past.

**Interviewee 2004-020:** Puzzles used by this therapist represent the client’s ability to put him or herself ‘back together’.
Again, expression of feelings and/or emotions, nurturing or self-care, and processing of trauma, leading to forgiveness and acceptance of self were the themes identified in Question 3.

Interview Question 4

The fourth Interview Question asked participants, “Why did you choose to use this technique (the one described in Interview Question 3) at this time?” Five themes were identified in response to this question. The first theme as to why the therapist chose to use the technique of play therapy at this time was the expression of feelings and emotions. Rationale for using play therapy was because the client could not express his or her feelings. This theme is supported by the following data.

Interviewee 2004-001: “Because she couldn’t express her anger, her feelings. She couldn’t talk about it.”

Interviewee 2004-003: “Trauma patients say, I don’t feel my feelings. They may not be able to say what they feel, but they can draw it.”

Interviewee 2004-007: “Because it was an affective moment when you were going with the emotion. Or, it is to stimulate movement in that direction.”

Interviewee 2004-009: This therapist frequently uses animals to represent people in the client’s life. Then, she has the client choose a spiritual figure. The therapist chooses a doll to represent her. The ‘doll’ speaks to the animals. The spiritual figure helps the client express his or her feelings.

Interviewee 2004-016: “Sand helps express emotions.”

Interviewee 2004-017: “They helped the client to express emotions.”

The second theme as to why the therapist chose to use the technique of play
therapy at this time centered on the *therapeutic relationship*. Developing a therapeutic relationship is an essential pre-requisite if the client is to trust the therapist to safely guide him or her in an exploratory journey of self. A safe, non-threatening environment facilitates this journey. The following excerpts from participants’ responses illustrate the importance of establishing a therapeutic relationship.

**Interviewee 2004-002:** “I focus on the therapeutic relationship. Previous relationships affect present relationships and I use the therapeutic relationship as a tool for looking at the past and healing it.”

**Interviewee 2004-015:** “The Rose Garden [exercise] is simple and non-threatening.”

**Interviewee 2004-016:** “If you don’t have trust, you can’t deal with autonomy. I use trust-building exercises.”

The third theme as to why the therapist chose to use the technique of play therapy at this time was to cultivate an early *developmental perspective*. Adult survivors have learned to not talk about what happened to them or how they felt about it (Simonds, 1994). As such, many adult survivors find it very difficult to share these experiences (Glaister & McGuinness, 1992). Even though they come to therapy as adults, it is their childhood experiences and feelings that they must face (Roth & Batson, 1997). Having kept their secret most of their life, the learned silence prevents them from talking freely about their past (Ross, 2000). Thus, by taking the adult back to the time of the abuse, through play therapy (Axline, 1947, 1969; O’Connor, 2000; Ross, 2000; Schaefer, 2003) the adult is able to communicate his or her experiences and feelings. By approaching therapy with the adult survivor from a developmental
perspective, the therapist can facilitate communication. The adult client can use the communication skills that they would have used at the time of abuse, if they had been able to do so. By going back to the developmental stage at the time of abuse, the client can communicate what he or she would have wanted to express at that time. Examples of using a developmental perspective follow.

Interviewee 2004-004: “Because the abuse occurred at those developmental stages. In the case of the client with anger, she wanted to trash my office, so I had to help her work it out.”

Interviewee 2004-006: “Sexual abuse occurred at an early developmental stage. The client did not learn to trust and needed to learn self-nurturing.”

Interviewee 2004-016: “I use a developmental perspective (Erikson). If you don’t have trust, you can’t deal with autonomy. I do an abuse assessment: what age the person was abused.” She then asks herself, ‘Where are they stuck?’ Trust-building exercises are next. This therapist has puzzles, games, crayons, and so forth, so that “they can get back to where they are stuck.”

The fourth theme that emerged as to why the therapist chose to use the technique of play therapy at this time was that treating adult survivors is a process that can lead to insight and healing. In general, the therapist assists the client in finding an anchor in a safer or happier time. The play therapy techniques allow the client to process the past in a less threatening manner (O’Connor, 2000; Schaefer, 2003; Ward-Wimmer, 2003). Most abused survivors learn to keep secrets; thus talk therapy can be very frightening. Through play, one can express feelings without fear of rebuke. The use of the sand tray, for example, allows for symbolism (Boik & Goodwin, 2000; McNally, 2001). It affords a safe approach to deal with horrific
memories and experiences. The client can remain at a distance until he or she is ready to engage in a more in-depth exploration. Tolerance builds until the client is able to experience more fully the feelings, thoughts, and emotions represented by the scene or activity in the sand. Usually, the client initially projects feelings onto figures, as in sand tray, animals, or through the media of art (Malchiodi, 2005; Simonds, 1994). Once the emotion is safely expressed, the client can begin to own the feelings and accept that what happened to him or her was not his or her fault. Clients come to realize that the horrific experience is not who they are (Ross, 2000).

Responses that illustrate the importance of a process-oriented approach are as follows.

**Interviewee 2004-005:** “I used this technique at Eagle Village and it worked, so I just continue to use it. It can be a very powerful awareness.”

**Interviewee 2004-011:** Speaking about using sand tray and drawing, this therapist explained, “You bring the person up to that point; then tie the figures to their feelings and wait until they are ready to deal with that and making sure they’re really okay with that.” She went on to say, “That is a way of getting in touch with their feelings symbolically. I think on more levels than just a cognitive level. They can talk about their experiences and not allow themselves to go back there.” This therapist continued by saying, “And it can also be, to some degree, a little distancing if you are doing it through the figure. When you have a figure there and they’re experiencing it, it’s different than your experience.” She concluded, “If you can deepen the experience in them, in the modality that you’re using, you can more fully experience it too.”
Interviewee 2004-012: Progress with the self-blaming client was slow and the therapist wanted “to help the client see that the pain and myriad feelings that she experienced were ‘normal’, given the circumstances. I also wanted to move to more right-brain activities to help her access more of her childhood experiences.” In this case, the therapist used play therapy interventions in every session, intermixed with discussions. The therapist concluded, “I used this one early on to help her understand her right to heal, and because it’s relatively non-threatening.”

Interviewee 2004-018: “I really believe in play therapy. I’ve seen amazing things that kids do and the projection and they can’t help it. And the grown-ups can’t help it either.” This therapist explained further, “When you have grown-ups play, it’s a much more pure form of free association. Grown-ups will do things with the toys that they don’t even recognize that they are actually doing something therapeutic.” She then added, “It’s more like dream work, where you are getting more of the unconscious than you would get just doing the talk therapy, and you can get to the inner child.”

The fifth theme that emerged as to why the therapist chose to use the technique of play therapy at this time was that of self-care. Trauma occurring in childhood affects the child’s ability to learn self-nurturing. This need for nurturing affects current relationships, emotions, and behaviors. Through play therapy, the client may gain insight into the past that affects present functioning. Guided by a trusted therapist, the client may reclaim his/her past, learning to love and care for self (O’Connell Higgins, 1994; Wolin & Wolin, 1993).

Self-blaming and strong defenses prevent clients from moving to a more joyful life. As the client realizes that he or she was not to blame for what happened and that
he or she is worthy of respect and love (Ross, 2000), nurturing of self is reflective of the doll or animal that was nurtured by the client in play therapy. The following excerpts from participants’ responses support this theme.

**Interviewee 2004-004:** “I had a woman who had been abused at ages 5 and 12. She was never allowed to play with adults. I had her go out and buy Christmas presents for a child of these ages. She bought a doll and brought it back to the next session. She giggled and laughed. She gave herself permission to take care of herself.”

**Interviewee 2004-006:** “Sexual abuse occurred at an early developmental stage. The client did not learn to trust and needed to learn self-nurturing.”

**Interview 2004-013:** Speaking about clients with DID, this therapist went on to explain, “I have a few DID clients who trigger in my play room.” The therapist invites them into the play room, where “they trigger into their system where they are children; it is a transitioning process. There’s some caretaker that is there to nurture the children. It is a good sign when they don’t want to go there anymore and are aware of the nurturing that they need. They become very empowered.”

**Interviewee 2004-020:** Because she knew she would see the client only three times, this therapist followed a plan. First, she had the client draw a person and make a scene in the sand. Processing of the drawing and sand tray “took the client back so far, I knew exactly what I was dealing with.” The second session involved clay activities, “which was also regressing, but soothing and those were far more guided.” In the third session, the therapist chose the puzzle, specifically because “the puzzle is about getting it back together.” This helped the client understand that, though her life had been difficult, she had the capacity to put it back together. The therapist summed
her rationale by saying, “I was doing that in a very cognitive, directive way, because I knew I would not see this woman again.” The therapist “was not going to send her out into the world without making sure she [the client] knew she could be put back together.”

Again, five themes emerged from Question 4 regarding why this particular technique was chosen. They are: (a) expression of feelings and emotions; (b) the importance of the therapeutic relationship; (c) cultivation of an early developmental perspective; (d) treatment as a process, which may lead to insight and healing; and (e) self-care.

Interview Question 5

In Interview Question 5, participants were asked, “Are there any other techniques that you frequently use?” Multiple responses to this question echoed those on the survey list (Table 8) and included: (a) journaling (Interviewees 2004-004 and 2004-007), (b) sand tray, (c) art, (d) anger management, (e) imagery, (f) role-play, (g) humor, (h) therapeutic games, (i) physical activity, (j) psychodrama, (k) puppetry, (l) music, and (m) dance. Additional techniques that were reported during the interviews included family sculpting, collages, Play-Doh or clay creations, tea parties, such games as jacks, marbles, cards, and Jenga, and ‘play back theater’. Responses were grouped into the following four categories: (a) those that fell into the category of art techniques; (b) experiential/expressive techniques, aimed at facilitating expression of feelings, emotions, and thoughts; (c) cognitive techniques; and (d) anger management techniques.
Malchiodi (2005) described the non-verbal expression of feelings and experiences as art therapy. A variety of media may be used including, but not limited to, drawing, painting, creating images in clay, sand, ceramics, paper, and other three-dimensional substances. The use of colors and different textures contributes to the expression. Thus, the first category in this listing of techniques is art and includes drawing, painting, coloring, clay or Play-Doh creations, sand tray, and collages. It is noted that several therapists gave multiple responses to this question. Often, the interventions that they used could be classified in more than one category. For this reason, examples of individual responses may be duplicated in another category. Responses that reflect the use of art follow.

**Interviewee 2004-002:** “When I was in private practice, I sometimes had lower functioning clients. They weren’t always able to express themselves in words. I used art therapy, coloring, drawing, games.”

**Interviewee 2004-003:** “Any type of therapy that involves the creative side is set up with choices. [That includes] play therapy, art therapy, movement therapy, anger management.”

**Interviewee 2004-006:** “Play therapy can be anything from psychodrama to art therapy, to anger work with clay balls.” He added, “There is painting and finger painting, role play, sand, videos, and stories.”

**Interviewee 2004-008:** Although this therapist uses EMDR, she predominately uses sand tray. For clients with DID, she will have each alter pick a figurine to represent them. “They do a scene and each alter can say, ‘Who sees this from a different perspective?’” The ‘alters’ then give their perspective, but each one is witnessing it. This therapist asks her clients to make collages from pre-cut pictures.
The therapist explained that cutting out the pictures takes time, so she cuts them out herself, during meetings. Some of the provocative pictures elicit strong emotions/feelings.

**Interviewee 2004-010:** This therapist reiterated the use of sand tray and symbolism with adult clients, stating that “children actually don’t do as much on the symbolic level as adults.”

**Interviewee 2004-011:** This therapist often combines EMDR with sand tray and/or other expressive techniques, such as drawing and psychodrama. While talking about EMDR work, she explained, “I go in a little slower and I think the sand tray and some of the other expressive works gives me a way in which to find a path.”

**Interviewee 2004-013:** A typical session with this therapist begins in the ‘intake room’. The client is asked to share any artwork that they have brought in (they are clued in ahead of time as to this procedure). The therapist and client then go into a studio room, where further exploration of the art takes place. Generally, sessions end in this room. However, the therapist and client may go back to the ‘intake’ room to dissociate from the art therapy experience.

**Interviewee 2004-014:** This participant uses sand tray and art therapy with adult survivors. Often, the client is given an art assignment as homework, which is then discussed in the next session.

**Interviewee 2004-016:** A variety of techniques were listed by this participant, including sand, finger paint, regular paint, coloring, Play-Doh, tea parties, games (for example, jacks or marbles), the use of colors (‘what does red mean?’), and sitting on the floor, talking to the child within the adult.
Interviewee 2004-017: This therapist listed art, sand tray, therapeutic games, and puppets.

Interviewee 2004-018: “No, just the techniques that I mentioned,” which were art, sand tray, and toys.

A second category of techniques was classified as experiential/expressive. Felber (2001) defines experiential as “the expression of feelings, emotions, and thoughts through creative arts and activities that utilize symbolism to communicate their meaning.” While art is included, he emphasizes dance, movement therapy, and role-playing. Malchiodi (2005) defines expressive therapy as the use of arts and play to facilitate change, problem solving, communication, and interpersonal skills. Examples include art, music, dance, drama, poetry, and sand tray. Although it is difficult to separate art, including sand tray, from this category, it was done to focus on music, dance, drama, and role-playing as unique techniques. The following participants’ responses illustrate this category.

Interviewee 2004-001: This therapist uses family sculpting. “We talk about issues in the present; how you would like your family to be.” (While a specific intervention, for the purposes of this study, family sculpting is categorized as role-playing.)

Interviewee 2004-003: “Any type of therapy that involves the creative side is set up with choices. [That includes] play therapy, art therapy, movement therapy, anger management.”

Interviewee 2004-009: “I do some role-play. I definitely try to move people into expressing their anger with words.”

Interviewee 2004-021: “Another thing we would use is dance therapy.”
The third category of techniques was cognitive. Mental processes involved in thinking, knowing, remembering, planning, and perceiving are basic elements of cognition (Antai-Otong, 2003). Cognitive therapy is based on the premise that illogical or distorted perceptions of events and/or people cause problems. Therapy challenges these beliefs, faulty reasoning, and negative-self statements (Antai-Otong, 2003; Beck, 1995). Cognitive techniques reported by participants in this study include the use of games and puzzles, journaling, problem-solving exercises, imagery, and relaxation exercises. Examples of the use of cognitive techniques follow.

**Interviewee 2004-004:** This therapist uses hypnotherapy “to get to the key memories.” “I use journaling big time.”

**Interviewee 2004-005:** Other helpful techniques to use, according to this therapist, is the use of puzzles. He will say, “This is your life.” He then asks them to put it back together. “If you don’t have the picture to look at, it helps them to problem solve. Ask them what their process would be? Most always, they will say do the border first.”

**Interviewee 2004-007:** “I use a lot of cognitive grounding sort of techniques, educational stuff.” He explained, “Because, while the person who dissociates needs to work through feelings, they also get very easily overwhelmed with feelings, so you have to do a fair amount of cognitive work.”

**Interviewee 2004-016:** In addition to art techniques, this therapist uses games.

**Interviewee 2004-020:** “I occasionally use the ‘Jenga’ game.” It may be a conversation piece or the therapist may put questions on each piece and the client can answer the questions or not. “It’s about building and reconstructing and building and reconstructing.”
The fourth category of techniques was *anger management*. While similarities existed, what was involved in anger management received the greatest variance among therapists. For some, this meant physical discharge of anger energy, through throwing (in a non-harmful manner) objects and processing the feeling. Others included role-playing or acting out in a dramatic presentation. For still other therapists, cognitive techniques, such as journaling and writing letter, were used to bring awareness of the emotion, and subsequent discharge of the negative energy. Specific examples from participants are as follows.

**Interviewee 2004-003:** This therapist simply mentioned anger management as an additional technique. She is an art therapist who had earlier in the interview explained throwing clay balls and blowing up balloons and then poking them with a pin. Art is used to express anger. After its expression, she will role play or discuss how a situation might be handled in the future.

**Interviewee 2004-004:** “For someone with anger issues, I may have them break clay pots or scream in the car.”

**Interviewee 2004-006:** “Play therapy can be anything from psychodrama to art therapy, to anger work with clay balls.”

**Interviewee 2004-009:** “Anger management . . . what’s constructive and what’s destructive anger that I impose on people. I do some role play. I definitely try to move people into expressing their anger with words because I think that can reduce the likelihood of acting it out, especially if you can express your anger with words about what you’re truly angry about. So it’s kind of like anger having to do with displacement; anger towards something deep. Reducing displacement and generalization. I think that when someone has been abused in a terrifying way by
somebody, they tend to generalize their anger because they’re too afraid to become conscious of being angry at someone they are so terrified of, or the experience of what happened by that person to be completely dissociated because of the terror, so they need to be conscious of who to get angry at and direct the anger toward that person and put it into words. I think it not only is going to help a person not act out physically, but be much more to the point as far as letting them express what they are angry about so I use that in psycho-traumatic-type techniques. I’ll take a dummy quite often and put it in a chair and do that. Then, let me say what they feel. Then, humor may come in. If I have a person who is physically out of control, I would not let them beat it up. I definitely want them to express their anger through words.”

In summation of Question 5, which concerned other techniques that were used, four categories or themes were identified. They are those techniques that fall into (a) art, (b) experiential/expressive, (c) cognitive, and (d) anger management categories.

Interview Question 6

In Interview Question 6, participants were asked, “Is there anything else that you would care to share about play therapy with adult survivors?” Five themes were identified in response to this question. The first was treatment as a process. Three therapists specifically addressed treatment of adult survivors as a process that occurs over time. An important aspect of play therapy is that it reduces the time needed for the client to get in touch with his or her feelings and emotions and thus facilitates a quicker movement toward resolution and healing (Gil, 1988; Gladding, 1993; Ross, 2000; Simonds, 1994). Examples of treatment as a process and time needed for therapy are described in the following participant responses.
**Interviewee 2004-001**: “In talk therapy, a person is on a treadmill. Using these techniques can wipe away two or three sessions. It helps people to express themselves, when they cannot do so verbally.”

**Interviewee 2004-003**: “It is a process. You can’t fix 18 years of trauma in a month. These people are survivors. They have learned to cope. They may be poor coping tools, but they figured it out on their own.” She added, “Trauma intensifies negative feelings from others, to a point where it interferes with regular development.” This therapist emphasized the necessity of a safe environment “where the client could come back repeatedly” and then concluded, “You can’t eat an elephant in one bite and you can’t undo or fix years of trauma quickly, but the play therapy helps the client to get there faster.”

**Interviewee 2004-013**: “I’ve witnessed so many tears in adult survivor drawings. I’ve seen so many new beginnings happen in drawings where the transformation occurs. Usually, the art therapy will parallel the progress that’s being done in therapy.” Working with a treatment team, this therapist explained that the art and play therapy that she did with the client was part of the process, not the entire process.

A second theme was the *timing of treatment*. Specifically addressing the timing in treatment, one therapist explained:

**Interviewee 2004-011**: “I think you have to really understand the difficulties that people experience in their abusive situations and not try to push someone into doing something until they’re ready.” This therapist emphasized going where the client wanted to go; not where she thought they should go or be. That, she said, was honoring the client.
The third theme that emerged in response to Question 6, which was if there was anything else that they would care to share about play therapy with adult survivors, was that of the importance of the therapeutic relationship, including safe environment and the therapist’s own needs. Excerpts that illustrate this theme follow.

**Interviewee 2004-002:** “I mainly focus on the process of the therapeutic relationship and what is going on with the client.

**Interviewee 2004-003:** “You need a safe environment where the person can come back repeatedly.”

**Interviewee 2004-006:** “Dr. Whitfield talks about how we have to first do work in our head and our heart.” He added, “Play therapy is about being vulnerable; it’s learning how to share; how to break bread with another. It’s learning how to cry with the client.” This therapist concluded by saying, “Therapists have to be doing their own work and having their own support system or they are going to get involved in an area where they are projecting their own feelings on to the client.” “That,” he said, “would be disaster for everyone.”

One therapist explained her rationale for using directive play versus non-directive play in the therapeutic relationship.

**Interviewee 2004-016:** “There are times to be reflective (Roger’s). That’s when they are in the child role. I use non-directive play then. I use directive play to get in touch with emotions.”

The fourth theme that emerged from Question 6, which was if there was anything else that they would care to share about play therapy with adult survivors, was that of spirituality.
Interviewee 2004-006: “The work has to include the spiritual component; a balance of mind, body, spirit.”

Interviewee 2004-009: “I definitely believe that change happens from deep inside. If you just talk about it on the top, you are not going to get into the unconscious.” The therapist continued, “If you are dealing with imagery through art, or if you bring in something spiritual, you’re going to make a change both cognitive and emotional that’s going to have root.” She then gave an example: “A cognitive [approach] would be like clipping the leaves on top of an infected tree. If you put some plant food and something that handles the infection into the earth, that’s more how I see it; and I think you get to the earth with play and art and spirituality.” She suggested, “Use the play and art as much as you can. That will always get deeper and more memorable and have a more profound, lasting effect.”

The fifth theme, which was if there was anything else that they would care to share about play therapy with adult survivors, was change in thinking, perception, or behavior as a desired outcome. The following excerpts from the therapists’ responses illustrate a desired change (outcome). The following responses exemplify this theme.

Interviewee 2004-007: “I do a fair amount of drawing with distorted body image.” Discussion of the drawings assists in a realistic perception of one’s body.

Interviewee 2004-008: This participant continued to talk about working with the sand tray and having the client pick figures to represent each alter. She also talked about different perspectives and looking at the sand tray from different angles. “A dissociated alter only sees a slice of life, so sand tray is a wonderful medium for dissociation. It gives them a chance to see that there is a bigger picture. What sand
tray lets you do is stand apart from whatever you are putting in the sand, and get some distance from it, but you are still attached to it, because you built it. It just allows you to look at things a little differently.” Another technique that this therapist uses is a drawing technique, where the client draws him or herself at present and then before the traumatic experience. It allows the therapist and client to discuss changes that have resulted from the abuse experience.

Interviewee 2004-009: “I definitely believe that change happens from deep inside. If you are dealing with imagery through art, or if you bring in something spiritual, you’re going to make a change both cognitive and emotional that’s going to have root.”

Interviewee 2004-010: “I think that in many, many cases the adults have learned ways of adaptation and coping skills, some of which are not particularly healthy and that’s usually what brings them in.” According to this therapist, few clients come to therapy for sexual abuse issues. It is through exploration of the past, that the connection with their present problems is made. “We’ll go back in the childhood and talk about issues.” Insight gained leads to resolution and the development of more effective coping skills.

Interviewee 2004-014: “It’s so much easier to talk about what’s in the sand tray with adults. If adults can get past the silliness of it, they can usually process a little bit without the fear of the emotion.” “They can stand back and look in,” she added.

Interviewee 2004-017: “It is imperative. It is a useful approach. It may help with the developmental stages. It allows them to be more expressive.”
One therapist simply stated:

**Interviewee 2004-005**: “Just that it works!”

In summary, five themes were extracted from the participants’ responses to Question 6. They are: (a) *treatment as a process*; (b) *timing of treatment*; (c) the *importance of the therapeutic relationship*, including the therapist’s own needs; (d) *spirituality*; and (e) *change in thinking, perceptions, or behavior as a desired outcome*.

**Phase 3 Theme Analysis for Word-Rich Data**

As previously stated, in a Grounded Theory approach to analysis of qualitative data, the data are simultaneously collected and analyzed (Streubert Speziale & Carpenter, 2003). Thus, the interview questions and their analysis that were just presented served to identify emerging themes. After consulting a statistician, versed in qualitative data analysis, the Theme Analysis for Word-Rich Data process developed by Cooper (2003) was chosen as the final method for analyzing qualitative data in this study.

Cooper’s (2003) Theme Analysis provided a prescribed method for analyzing and validating the same data, giving findings credibility. According to Cooper (2003),

Qualitative researchers often produce research data in the form of a verbatim record of participant dialogue captured during personal interviews or focus group participation. The recorded narrative is typically rich in expressions of opinions, attitudes, feelings, self-reported experiences, and the like. Analysis of this word rich data is often focused on uncovering common themes within the data.

Theme analysis of word-rich data is an adaptation of affinity analysis sometimes applied to word-rich data developed during brainstorming. The purpose of theme analysis is to summarize word-rich data collected during application of qualitative research methods (e.g. personal interviews or focus group dialogue). Theme analysis is a process for (1) uncovering common threads running through the data, (2) identifying representative comments.
illustrating or supporting each theme, and (3) identifying comments representing expressed diversity around each theme. (p. 1)

Because the intent of this qualitative research was to ascertain common themes in the use of play therapy with adult survivors, the Theme Analysis for Word-Rich Data offered an ideal avenue to determine those themes. The use of play therapy with adult survivors has been, to date, without a formal model for practice. Thus, this initial identification of themes provided a framework for a future practice model.

To conduct this analysis, each interview question and the responses from each of 21 participants were placed on individual index cards and then placed in six categories (by question) on a blank wall. A team of independent thinkers, consisting of a psychologist, a nurse educator with experience in working with abused children and in utilizing play therapy for hospitalized patients, and a nurse educator with a doctorate in educational leadership, who works as an informatics specialist, referred to as ‘themer’, silently re-arranged the cards into new categories. (See Appendix D for a complete description of the process.) When the team was satisfied with the new categories, a discussion, led by Cooper, followed. Themers were asked not only why they re-arranged the responses into different categories, but why they made subsequent re-arrangements. In other words, what was the justification for the new categories? The team then named the emerging themes. I was an observer during this initial activity. The themes were: (a) therapist focused, including therapist’s interest and comfort zone; (b) patient focus, with descriptors that included patient initiated, patient need, and therapist/patient match; (c) training of the therapist or how they came to use certain techniques; (d) alternate ways of expressing self, when resistance,
strong defenses, and non-conscious issues underlined impasses in therapy; (e) techniques to help the client express anger; (f) reasons why therapists selected the techniques that they did; (g) safety and nurturance, specifically, a non-threatening environment; (h) theoretical justification for techniques; (i) other, less frequently used techniques; (j) developmental perspective; and (k) spirituality.

As the discussion continued, the team decided to combine themes, as it was apparent that there was an overlapping of themes, and therefore, a more concise categorization was determined. At this point, I entered into the discussion of emerging themes. The team members and I were also asked by Cooper to comment on the process. The team members and I expressed satisfaction in the process of arriving at the themes. The team members and I agreed that the new themes more accurately identified the themes that emerged from the data. The team member who was a psychologist exclaimed, “It’s like a fluid, non-numerical factor analysis.” The final categories were: (a) non-threatening, therapeutic environment, (b) desired therapist characteristics, (c) successful techniques, (d) developmental perspective, (e) justification for using play therapy, and (f) spirituality.

Non-threatening Therapeutic Environment

The importance of a trusting relationship with the therapist was emphasized by the participants throughout the interviews. The need for trust is due to the fact that survivors fear intimacy of any kind, learning very early in their lives that people are not to be trusted. Several therapists also emphasize the warm atmosphere of the therapy room, including comfort measures such as a blanket or pillow, a rocking chair, and toys that extend an open invitation to play. Responses that reflect the
importance of the therapeutic relationship in working with adult survivors are as follows.

**Interviewee 2004-002:** “I focus on the therapeutic relationship. I work to establish that; trust.”

**Interviewee 2004-003:** “You need a safe environment where the person can come back repeatedly.”

**Interviewee 2004-006:** “Play therapy is about being vulnerable; it’s learning how to share; how to break bread with another. It’s learning how to cry with the client.”

**Interviewee 2004-011:** “I think you have to really understand the difficulties that people experience in their abusive situations and not try to push someone into doing something until they’re ready.” This therapist emphasized going where the client wanted to go; not where she thought they should go or be. That, she said, was honoring the client.

**Interviewee 2004-012:** “The key issues for using play therapy with adults are: (a) my relationship with them, and (b) the timing. There must be decent rapport and trust before I do much play therapy, although, I use humor from the start.” The therapist went on to give an example of working with an adult survivor. “During a rather intense session, she regressed and dissociated a bit. I began to use toys to help her feel safe and to help her with her feelings.”

**Interviewee 2004-015:** Referring to the Rose Garden exercise, this therapist explained, “It’s simple and non-threatening.”
Desired Therapist Characteristics

This category combined the therapist's training/exposure to play therapy, comfort level in doing play therapy with adult clients, and the therapist's own inclinations (similar to comfort level in personal traits that lend themselves to using play therapy techniques). Examples of training and exposure to play therapy are reflected in the following therapist responses.

**Interviewee 2004-001**: “I work in a Trauma Program. I learned from Dr. Ross and Melissa Cauldwell. I started with leading an anger management group. One of the therapists that I worked with would go into the gym and throw clay balls. We also have an art therapist here. I picked up some techniques from her.”

**Interviewee 2004-003**: “Well, I am an art therapist. I learned about Dr. Ross and the Trauma Model and the person’s inability to express some feelings. It is less threatening to express painful experiences and feelings through art.”

**Interviewee 2004-005**: “Well partially because of the training at Andrews, although I don’t think they had a course specifically in play therapy with adults. I did my work at Eagle Village, where they did live interventions.” He applies these interventions to his work with adults.

**Interviewee 2004-006**: “I see clients at Forest View and have worked with Dr. Ross there. He specializes in victims of sexual abuse. Dr. Ross and Dr. Whitfield talk about the Trauma Model. They use play therapy at Forest View. Adults who have been sexually abused as children have attachment issues. I give them an object to represent where they were at the time of the abuse. They keep it with them. It serves to ground them. You build on trust and go to object permanence.”
**Interviewee 2004-009:** “I have an art therapy background. When I started understanding play therapy, all the things that I would use art for, it made sense to think about play therapy. I shared an office with a sand tray therapist, so I learned about that.”

**Interviewee 2004-011:** “It just seemed natural. Talk therapy allows people to stay in their head, where expressive therapy when you are using more than one sense and one way in which to discuss and process what’s happened. I think it’s more affective.”

**Interviewee 2004-013:** “Mainly, because I am a registered art therapist. That’s the most effective form of therapy with adult survivors.”

In addition to training, the therapist’s interest and inclinations to use play therapy are depicted in the following examples.

**Interviewee 2004-015:** “My own gifts [for play and art-type activity] make it easy to incorporate fantasy and imagery exercises. Clients have responded well. At times, the non-rational opens a lot of other doors.”

**Interviewee 2004-018:** “I really love play therapy. I decided, ‘Why don’t we take flashbacks out of the grown-ups heads?’ I decided that would be a good way to have them show me with toys or art what a flashback looks like.”

**Interviewee 2004-020:** “Because I am a play therapist and that’s what I do. It’s simply part of the repertoire that I have to offer people, and adult survivors are so often choked in non-verbal places that play invites expression that goes far beyond words.”

**Interviewee 2004-021:** “I am a music therapist. I use music to assess clients and to help patients get in touch with their feelings.”
Successful Techniques

A great variety of techniques were given in response to Interview Question 3, which asked participants to describe a session in which they used play therapy techniques with adult survivors, and Interview Question 5, which asked participants if they used any other play therapy techniques. Two main subcategories emerged here, related to intent. If the intent of the therapy session was to assist the client in expressing feelings, projective art techniques, drama, sand tray, and symbolic objects or metaphors were used. If the intent of the session was to manage anger, more physically releasing activities were employed, such as throwing clay balls, punching a bag, or discharging the anger in a non-harmful way. Examples of successful play therapy techniques follow. First are those techniques utilized to assist the client in expressing his/her feelings, emotions, or experiences.

Interviewee 2004-002: “I try to follow the affect. I might introduce role-playing or use of imagery. I may have them do outside of session, journaling or drawing, to get in touch with their feelings.”

Interviewee 2004-003: “I am thinking of a patient who was abused and expressing anger at her mother. I asked her to draw her anger. Trauma patients say, I don’t feel my feelings. They may not be able to say what they feel, but they can draw it.”

Interviewee 2004-005: “I have clients draw pictures of themselves and what they are feeling.”

Interviewee 2004-008: “I have clients do collages. I have bins of cut up pictures of all different kinds. I have some pictures that can be quite provocative [and elicit various emotions].”
Interviewee 2004-010: “I use sand tray. I ask the client to talk to me about what she created and any feelings that came up. From there, it usually leads into a discussion of whatever is a significant issue.”

Interviewee 2004-011: “I had a client who was a molested victim. She was feeling a sense of shame about sexual relationships with her husband. I had her draw the shame.”

Interviewee 2004-012: “Sand tray has been very useful. One woman had been having difficulty remembering details of a horrific childhood sexual and physical abuse. I gave her a bendable dinosaur and asked her to put a cast on it, because it was hurt. I then asked her to tell the dinosaur’s story. Afterward, she tearfully commented that she was like the dinosaur – innocent, but hurt in many ways.”

Interviewee 2004-013: “I have them do art work, [which] we explore.”

Interviewee 2004-014: “I use sand tray. They can see the emotion or incident much more clearly.”

Interviewee 2004-016: “I use sand, finger paint, regular paint, Play-Doh.”

Interviewee 2004-017: “I use art, sand tray.”

Interviewee 2004-018: “I was working with a lady that was severely abused and she was having flashbacks, where eyes were staring at her. We mostly did drawings.

Interviewee 2004-019: “I have used coloring and sand. Sand is really a very powerful medium. I had one client, a female sex offender, with probably one of the most tragic and traumatic histories that I have ever encountered. Coloring and dolls
were pretty impactful for her. I try to get them into the sand, because usually sand
will open up a lot.”

**Interviewee 2004-020:** “I put a puzzle in front of a woman. It’s a blank
puzzle. I asked her to express in any way that she was happy. She could create a
scene, use words or colors to fill the puzzle with her own sense of safety and
happiness. We talked about what that was for her. Then, we took the puzzle apart.
She wept as she put the puzzle back together. The muted colors represented the depth
of her trauma.”

**Interviewee 2004-021:** “I would use large pieces of paper and multiple
crayons, chalk, or markers. We talk about the pictures and what the client sees and
feels.”

Examples where the intent was to discharge anger include the following.

**Interviewee 2004-001:** “I go to the anger. I try to get them in touch with what
their body is feeling. If they can’t express themselves, we might go into the gym. I
will have them start by throwing clay balls at the wall. Then, I have them talk about
what they are feeling.”

**Interviewee 2004-003:** “Trauma patients; have issues with relationships, grief
and loss, anger – we do specific things to get the body involved. Even though they
may feel the anger in their body, they cannot express it verbally. In addition to
throwing clay balls at the wall, I may have them blow up balloons and then poke
them with a pin. That discharges the anger.”

**Interviewee 2004-004:** “I may give an assignment to break clay pots or yell
when they are in the car, as a way of discharging the anger. I had a client once who
came in and was in anger at the time. She said she wanted to rip my office apart. We
went into the playroom and made Play-Doh balls. We made an image of the abuser and had her throw the balls at it.”

**Interviewee 2004-009:** “I do role-playing. I put a dummy in a chair and say what they feel. If they are out of control, I do not let them beat it up.”

Developmental Perspective

When a child is abused, he or she does not develop in the normal pattern. Developmental tasks that correspond to the age of abuse are short-circuited. By going back, through the use of play therapy, the adult survivor may resolve early conflicts that plague his/her present life (Allan, 1988; Gladding, 1993; Ross, 2000; Thompson & Rudolph, 1988). The adult survivor may gain a new definition of self, with the realization that he or she was not to blame for what happened to him/her. Especially, when the abuse occurred prior to language development, the use of play therapy may help the client express what he or she could not then or presently express. Medicine has long recognized the need for retraining in the case of injury to the brain, where the patient has to learn to walk again; sometimes, crawling first (J. Leonard, personal communication, October 24, 2003; Taub, 1994).

Interview Question 2, “How do you determine which clients you will use play therapy with?” and Interview Question 4, “Why did you choose to use this technique at this time?” brought out the need for a developmental history assessment. The following participant responses support the need for a developmental history assessment.

**Interviewee 2004-004:** “I’ve had clients who were abused at pre-verbal stages. You have the person re-work those early developmental stages.”
Interviewee 2004-006: “One therapy does not fit all for adults with sexual abuse. If they are dissociating, you have to design your therapy to the level that they are at.” Referring to a specific client, the therapist stated, “Sexual abuse occurred at an early developmental stage. The client did not learn to trust and needed to learn self-nurturing.”

Interviewee 2004-008: This therapist had two separate rooms, one with a sand tray and toys. She explained how she would invite a client with DID to “have the kids tell their story.”

Interviewee 2004-016: “I use a developmental perspective (Erikson). If you don’t have trust, you can’t deal with autonomy. I do an abuse assessment: what age the person was abused.” She then asks herself, Where are they stuck? Trust building exercises are next. This therapist has puzzles, games, crayons, and so forth, so that “they can get back to where they are stuck.”

Interventions 2004-019: This therapist looks for indicators of early trauma in her assessments, especially trauma that occurred from birth to ages 3 or 4. “Kids of that age do not have the kind of brain development to put that kind of trauma into words.” She therefore uses more experiential techniques.

Justification for Using Play Therapy

Play therapy appears to help the client express feelings and emotions that he or she may not be able to express otherwise. It assists resistant clients and those with strong defenses to engage in the therapeutic process. It helps the client tell a horrible story, while supporting him/her in a journey of healing (Gladding, 1993; Simonds, 1994). According to three therapists in this study (Interviewee 2004-001; Interviewee 2004-003; Interviewee 2004-020), play therapy often achieves its purpose quicker.
than traditional talk therapy. Evident throughout the interviews, justification for using play therapy was primarily addressed in Interview Questions 2 (determining which clients to use play therapy with) and Interview Question 4 (why was the particular technique chosen). The ability to express feelings and emotions that she or he may not be able to express otherwise are supported by the following therapists’ responses.

**Interviewee 2004-001**: “If they can’t express themselves, we might go into the gym. I will get them started by throwing clay balls at the wall. Then, I have them talk about what they are feeling. I have picked up some art therapy techniques that help the client express feelings and emotions.”

**Interviewee 2004-002**: “Because it was an affective moment, when you were going with the emotion.”

**Interviewee 2004-003**: “Trauma patients may not be able to say what they feel, but they can draw it.”

**Interviewee 2004-004**: “I used this technique with adolescents and it worked, so I continue to use it. It can be a very powerful awareness.”

**Interviewee 2004-011**: “I use sand tray. You tie the figures to their emotions.”

**Interviewee 2004-012**: “I wanted the client to see that the pain and myriad feelings that she experienced were normal, given the circumstances. I wanted to move to more right brain activities to help her access some more of her childhood experiences. I began using play therapy interventions every session.”
Interviewee 2004-014: "When they get stuck, it’s about some form of powerlessness. I have them put it in the sand. I say to them that they can create their story or the problem."

**Spirituality**

Complete healing must be of mind, body, and spirit. Two therapists specifically addressed the spiritual aspect of healing adult survivors.

Interviewee 2004-006: "The work has to include the spiritual component; a balance of mind, body, and spirit."

Interviewee 2004-009: "I have the client choose an animal to represent how they felt in a relationship. I then have them choose an animal to represent the mother while this was going on. And then choose a spiritual figure within the room. The spiritual figure helps them to express their feelings and clear the truth about what was happening here and who was responsible. Sometimes I do a prayer of renunciation. I declare the power of the gentle shepherd. I ask God to bless the client with a deep knowledge that she/he was good, kind, and strong."

In summation of the Theme Analysis for Word-Rich Data, note must be taken of concerns voiced by team members, including my own. The lack of a universally accepted definition of play therapy with adult survivors, as well as varying degrees of preparation of the therapists, pointed out the need for a clear theoretical framework. Certified play therapists must undergo years of education and supervision in order to work with children; yet there is no regulation for using play therapy with adult survivors.
Summary of Chapter 4

Results from this initial study indicated the use of play therapy with adult survivors by 64.9% of the participating therapists in the study. An additional 110 potential participants responded to the initial email request to complete the online questionnaire, stating that they did not fit the criteria for participation because they (a) worked with children only; or (b) were retired or not actively doing therapy with clients. Those who declined participation were encouraging and expressed interest in the topic. Research Question 1 asked, “To what extent is play therapy used with adult survivors?” The small sample size requires caution in generalization, but the findings from this initial study are indicative of interest and use of play therapy with adult survivors. Those who participated in Phase 3 in-depth interviews were most enthusiastic and provided actual case scenarios where they used play therapy with their adult clients.

The second research question asked what were common techniques used by therapists who work with adult survivors. The most frequently selected techniques were: (a) journaling, (b) sand tray, (c) art, (d) anger management, (e) imagery, (f) role play, and (g) humor.

The third research question asked how therapists who use play therapy rate the effectiveness of play therapy with adult survivors. The mode and median effectiveness were both $5 = \text{very effective}$. On a 5-point Likert scale, with $5 = \text{very effective}$ and $1 = \text{ineffective}$, 81% of the participants selected a 4 or 5.

During the qualitative analysis, data were initially placed in six categories, to represent the six interview questions and their responses. As themes began to emerge from the qualitative data, new categories or themes were identified, expanding the list.
of themes to 11 themes. The analysis team, however, realizing that there was an overlapping among the themes, re-arranged the categories or themes, until the final 6 themes were identified. These 6 themes were: (a) non-threatening, therapeutic environment, (b) desired therapist characteristics, (c) successful techniques, (d) developmental perspective, (e) justification for using play therapy, and (f) spirituality. These final 6 themes are the suggested building blocks for a model for the use of play therapy with adult survivors. This model is presented in chapter 5.
CHAPTER 5

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

A brief summary of chapters 1 through 4 is presented, followed by a discussion of the findings and their significance. Next, implications for practice, including a proposed model for practice, are presented. Finally, recommendations for ethical practice, theory development, and further research are offered.

Summary of Chapters 1, 2, 3, and 4

Chapter 1 introduced the significance of the problem of sexual abuse and its long-term effects (Gil, 1988; Herman, 1992; Stean, 1988). Few studies have looked at treatment approaches for adult survivors of childhood sexual abuse. I was unable to find any studies that specifically focused on the use of play therapy with adult survivors, although it is frequently discussed and presented as an important intervention in play therapy conferences. Play therapy, however, is used extensively with children who have been abused and is well documented (Axline, 1947, 1969; Brown & Prout, 1989; Kratochwill & Morris, 1991; McMahon, 1992; O'Connor, 1991). The research literature and practice wisdom strongly suggest that trauma of sexual abuse in childhood sets the stage for adult mental health problems and faulty relationships (Browne & Finkelhor, 1986; Simonds, 1994). Therefore, it was
postulated that play therapy that assists children in resolution of trauma might also do the same for adult survivors. By creating a safe and warm environment through play, the adult client might be able to resolve issues of abandonment, mistrust, shame, fear, and guilt.

**Purpose**

The purpose of this study was to explore the use and effectiveness of play therapy techniques with adult survivors of childhood sexual abuse. There are many adult survivors who have never sought therapy or have found it to be ineffective for the underlying cause of their adult physical and emotional problems – childhood sexual abuse. Physical problems, alcohol and drug abuse, depression and suicide attempts, relationship problems, and anxiety, including posttraumatic stress disorder and panic disorder, are only some of the issues that confront the victims of childhood sexual abuse later in life (Browne & Finkelhor, 1986; Gil, 1988; Herman, 1992; Raison & Miller, 2003; Stean, 1988). Traditional talk therapy may initially appear appropriate until the major cause of the client’s distress is discovered – childhood sexual abuse. Because the abuse occurred in childhood, an approach that would reach the inner child of the past seemed worthy of exploration. Informal discussion of using play therapy with adult survivors began to surface among therapists. The time had come to explore this potential effective and efficient approach to therapy with adult survivors of childhood sexual abuse.
Overview of Relevant Literature

Chapter 2 provided a summary of the historical development of play therapy, along with a review of research on adult survivors. Research in the past has focused on symptoms and long-term effects of childhood sexual abuse (Bagley, 1991; Bifulco et al., 1991; Bondewyn & Liem, 1995; Chu et al., 1999; Gladstone et al., 1999; Golding, 1994, 1999; Kirby et al., 1993; McCauley et al., 1997; Sachs-Erickson et al., 2005; Weiss et al., 1999; Williamson et al., 2002; Zlotnick et al., 1995), but not on using play therapy with adult survivors.

A major drawback in treating adult survivors has been the multiple symptoms that adult survivors report when they are treated in the medical and mental health facilities (Ross, 1997). Because each survivor exhibits his/her own unique cluster of symptoms, the treatment generally focuses on those specific symptoms and the subsequent diagnoses. For example, depression is common among survivors (Gladstone et al., 1999; Levitan et al., 1998; Weiss et al., 1999). Depending on the clinician, the approach to treating the adult survivor with depression can be varied. It has been in recent years only that Dissociative Identity Disorder (DID) has surfaced as a predominant diagnosis in adult survivors (Chu et al., 1999; Lewis et al., 1997). Posttraumatic stress disorder (PTSD) is a frequent diagnosis seen in adult survivors (Gelinas, 1983; Greenberg & van der Kolk, 1987; Herman, 1992; Ross, 1997; Roth & Batson, 1997; Simonds, 1994). Treatment approaches for clients with both DID and PTSD vary depending on the therapist and, in some cases, the treatment center.

Cognitive theory underlies many treatment strategies. Adults are expected to gain insight and get in touch with their feelings. Journaling is a popular technique
that is utilized (Bass & Davis, 1988; Purcell, 2001; Ross, 1997). Eye Movement Desensitization and Reprocessing (EMDR) therapy, developed by Shapiro, has resulted in successful treatment for clients diagnosed with PTSD (Shapiro & Forrest, 2002). Parnell (1999) proposes EMDR as the treatment of choice for adults abused as children.

Many survivors of childhood sexual abuse have great difficulty expressing themselves (Glaister & McGuinness, 1992). Art (Adamson, 1984; Esman, 1988; Glaister & McGuinness, 1992; Liebmann, 1986), music (Moreno, 1985; Shulberg, 1981) and play (Blatner & Blatner, 1997; Gil, 1991) provide a media for expression of painful feelings, thoughts, and emotions. Gladding (1992) has promoted the use of the creative arts: music, dance, imagery, visual arts, literature, drama, play, and humor for use with clients of all ages.

Very few studies, however, have examined the effectiveness of treatment approaches with adult survivors (Edmond & Rubin, 2004; Edmond et al., 2004; Simonds, 1994). In fact, I was unable to locate any evaluative studies that explored the use of play therapy with adult survivors.

**Methodology**

Chapter 3 provided the framework for this study. Because little was known on the use of play therapy with adult survivors, an exploratory approach was indicated. Answers to the following research questions were sought through triangulation of initial qualitative, quantitative, and subsequent qualitative data collection and analysis:
1. To what extent is play therapy used by therapists who work with adult survivors of childhood sexual abuse?

2. What techniques are commonly used by therapists who work with adult survivors of childhood sexual abuse?

3. How do therapists who use play therapy with adult survivors of childhood sexual abuse rate the effectiveness of play therapy techniques?

The study was conducted in three phases. In Phase 1, a pilot study was employed to obtain initial insight into the use of play therapy with adult survivors. This understanding, in turn, assisted in the development of an online survey (Phase 2) and subsequent target questions for Phase 3 interviews.

Sample

Six therapists, who work with adult survivors, were interviewed in Phase 1. Of the six, three were women and three were men. Four were in private practice; one worked in a university counseling center, and one worked in a trauma program in an inpatient psychiatric facility. All had over 5 years of experience in working with adult survivors. Two of the participants had Ph.D. degrees in psychology; one had a Master's degree in Counseling; and three had MSW degrees. All lived within a 60-mile radius of the researcher and, therefore, were accessible for in-person and phone interviews. They were chosen because of self or supervisor identification of practice with trauma clients.

Participants for Phase 2 were drawn from two sources: (a) The Association for Play Therapy Directory (2003), and (b) Psychology Today's Therapist Directory 2003 Midwest. The Association for Play Therapy (APT) listed 434 registered play
therapist supervisors in the directory who had provided email addresses. Minimal requirements to be a registered play therapist supervisor are: (a) a master's degree, which must include content in “child development, theories of personality, principles of psychotherapy, child and adolescent psychopathology, and legal, professional, and ethical issues” (APT, 2003, p. 5), (b) at least 150 clock hours of play therapy instruction, (c) “national/regional medical/mental health board licensure or certification” (APT, 2003, p. 5), (d) 5 years of direct patient contact post-master’s, (e) 500 hours of supervised play therapy experience, (f) an additional 500 hours of play therapy experience, and (g) 4 hours of supervisor training. Because of their experience with play therapy, it seemed that this was an appropriate population to sample.

The *Psychology Today Therapist Directory* (2003) listed 90 therapists who identified themselves as working with sexually abused clients and who provided email addresses. Utilizing this directory potentially afforded an unbiased sample since it was unknown if this population used play therapy or other modalities in treating adult survivors.

All of the 434 registered play therapist supervisors and the 90 therapists listed in *The Psychology Today Therapist Directory* (2003), for a total of 524 potential participants, were contacted by email, requesting participation in the study.

One hundred and thirty-four emails were returned, undelivered, with addressee unknown. This brought the sample population down to 390. One hundred and ten therapists responded by email, but disqualified themselves because they: (a) only worked with children and did not treat adult clients; (b) were retired; or (c) not
currently seeing clients in therapy. This further reduced the pool to 280.

A second email request was sent to potential participants who had not previously responded. See Appendix A. In Phase 2, a total of 37 participants completed the online survey. Six of these were those who participated in the pilot study.

Of the 37 Phase 2 participants, only 22 identified themselves and listed contact information. All 22 were contacted by either phone or email. Several attempts to reach one potential participant failed. The remaining 21 participants were interviewed.

Among the 21 participants in Phase 3, 12 were Registered Play Therapy Supervisors, suggesting that they possessed the knowledge and expertise in using play therapy with adults was invaluable for this study, and 9 were non-APT therapists (which included the 6 therapists who had also participated in Phase 1).

What is important in qualitative research, according to Lincoln and Guba (1985), is that data are collected until a point of saturation or redundancy occurs. Data saturation and redundancy occurred early in the interviewing process, as repeated themes, such as rationale for using play therapy with adult survivors, techniques, trust issues, and the importance of an early childhood trauma assessment, arose. Thus, the 21 study interviews sufficed to meet the research objectives. Four participants were male; 17 were female. Geographical representation from all correspondents included 25 states and the District of Columbia. Interviewees came from California (2), District of Columbia (1), Illinois (1), Maine (1), Michigan (7), Minnesota (2), Missouri (1), New York (1), Ohio (1), Oregon (1), Pennsylvania (1), and Texas (2).
Instrumentation

Data from the pilot interviews were used to construct the Phase 2 Online Survey (see Appendix C). The online survey provided forced choices, as well as space for write-ins. Quantitative data obtained from the online survey were analyzed using descriptive statistics. A correlation coefficient was calculated to evaluate the significance of the relationship between the percentage of practice with adult survivors and the therapists' perceived effectiveness of using play therapy with adult survivors. A $t$ test was calculated to evaluate the significance of the therapists' academic preparation (doctorial versus master's degree) and the perceived effectiveness of using play therapy with adult survivors. The Theme Analysis for Word-Rich Data (Cooper, 2003) was used to analyze data from the in-depth interviews in Phase 3. This method of analyzing qualitative data allows the researcher to (a) uncover common themes running through the data; (b) identify representative comments supporting each theme; and (c) identify comments representing diversity among themes. An analysis team, led by a skilled facilitator, provided an objective analysis (Cooper, 2003).

Findings

Results of this study were presented in chapter 4. The use of play therapy with adult survivors of CSA by 64.9% of the participating therapists in the study suggests a viable avenue to treating clients with an often hidden and painful past. Therapists interviewed reported that through play therapy, clients express what they could not otherwise verbalize in traditional talk therapy.
Erikson’s Psychosocial theory was the most common (56.8%) developmental theory that influenced therapists in this study. Mahler’s Object Relations theory followed with 37.8%. Sullivan’s Interpersonal theory and Piaget’s Cognitive theories each received 7%. Freud’s Psychoanalytical (4%) and Kohlberg’s Moral Developmental theory (2%) were selected less frequently. Approaches used in therapy by participants in this study were as follows: (a) eclectic (43.2%), (b) experiential (21.6%), (c) expressive (21.6%), (d) cognitive (16.2%), (e) interpersonal (13.5%), (f) trauma theory (10.8), (g) behavioral (8.1%), and (h) psychoanalytical (5.4%).

In descending order of frequency were the presenting problems of clients with whom play therapy was used by the participants in this study: (a) depression (56.8%), (b) PTSD (54.1%), (c) sexual abuse (45.9%), (d) anxiety (40.5%), (e) DID (27%), (f) substance abuse (16.2%), and eating disorders (13.5%). The most commonly used techniques used by the therapists in the sample were, in descending order of frequency, (a) journaling (67.6%), (b) sand tray (62.2%), (c) art (59.5%), (d) anger management (54.1%), (e) imagery (54.1%), (f) role play (48.6%), and (g) humor (40.5%). The remaining techniques identified each received less than 25%. A complete breakdown can be found in Table 8 of chapter 4.

A 5-point Likert scale was presented on the study survey to assess the effectiveness of play therapy with adult survivors. Anchors were 1 = Ineffective, 3 = Moderately Effective, and 5 = Very Effective. The mode and median effectiveness were both 5 = Very Effective. Eighteen therapists selected Very Effective; 12 selected 4 on the scale; 4 subjects selected Moderately Effective; 1 therapist selected 2 on the
scale. No one selected *Ineffective*. There were two missing cases. In sum, 81% of the participants selected a 4 or 5, suggesting a more than moderate effectiveness of the play therapy techniques.

Though the quantitative sample size was small, the real-life stories told by the therapists in the qualitative interviews confirmed the existence of play therapy with adult survivors of CSA and its effectiveness.

In addition to answering the research questions, themes emerged from the Theme Analysis for Word-Rich Data (Cooper, 2003). These themes were used in developing a model for practice with adult survivors of CSA.

The six themes that emerged from the team analysis were:

1. *Non-threatening, therapeutic environment*
2. *Desired therapist characteristics* (preparation, experience)
3. *Successful techniques*
4. *Developmental perspective*
5. *Justification for using play therapy*

**Discussion**

The first research question, “To what extent is play therapy used by therapists who work with adult survivors of childhood sexual abuse?” was supported by 64.9% affirmative response rate (yes, they used play therapy with adult survivors) of the study participants. Additionally, more than 25% of the 110 potential participants, who disqualified themselves from the study, expressed written support and/or interest in the topic, suggesting a potential readiness in the field to use play therapy with adult
survivors. Data from 21 in-depth interviews richly portrayed real-life case scenarios where play therapy was used with adult survivors. It would appear safe to conclude support for the use of play therapy with adult survivors. To today’s clinician, this may suggest a future trend in treating adult survivors of CSA. Knowledge of the actual extent of use, however, is limited by the study’s small sample size. Therefore, the reader is encouraged to consider the results of this initial study as in indicator of a potential treatment modality for adult survivors.

The second research question asked, “What techniques are commonly used by therapists who work with adult survivors of sexual abuse?” Multiple responses provided many therapeutic tools to use. The most commonly selected technique was journaling. Journaling was chosen by therapists of various theoretical backgrounds and academic preparation; thus appearing to be a universal tool, effective with children, adolescents, and adults. Journaling allows the client a safe passage within the self; a way of expressing in writing what may be difficult to verbalize to another person. It can be a catalyst for insightful revelations.

Sand tray was another frequently selected (62.2% of the sample) technique. Sand tray can be an extremely effective technique as the client can draw in the sand or put objects in the sand to represent traumatic experiences and conflicts. Then, the objects can be re-arranged or the drawing ‘erased’ to represent resolution or closure (Boik & Goodwin, 2000; Malchiodi, 2005; McNally, 2001).

Art therapy was selected by 22 of the 37 participants, who completed the online survey. Art therapy (Malchiodi, 2005) utilizes a variety of media; the basic principle being the expression of feelings, thoughts, and experiences in a non-verbal manner.
The use of colors and different textures in drawings, paintings, clay objects, ceramics, or other three-dimensional substances contributes to the expression and its interpretation. According to Dr. Colin Ross (2000), “art therapy is a tunnel through the defenses” (p. 341).

Anger management was a frequently selected technique (54.1% of the sample). Anger management includes (a) physical activity such as running, exercising, and dancing; (b) throwing of clay balls against an oil-base painted backboard, then processing the anger (Ross, 2000); (c) didactic and cognitive recognition and restructuring (Ross, 2000); and (d) other means of appropriately discharging and processing the anger.

Imagery was also selected by 54.1% of the study participants. Imagery, as used in therapy, is a mental perception in the absence of appropriate stimuli (Finke, 1989). Images may be past experiences or projected future experiences. Guided imagery, or visualization, as it may also be called, is frequently used as an introduction to relaxation exercises as well as to assist a person in focusing on a happier time. It may be used as part of goal attainment; that is, imaging or visualizing achievement of a goal.

Eighteen of the 37 participants who completed the online survey selected role-play. Through role-play, clients may practice assertive skills, rehearse communicating difficult messages, and/or gain insight into interpersonal relationships. It allows the client to process experiences and interpersonal relationships in a safe and successful manner.
Play therapy techniques, as identified and used by the therapists in this study, provide ideas for other practitioners as they struggle to find a timely, facilitative, and cost-effective approach to working with adult survivors. An approach that can unlock a traumatic past, leading to resolution, healing and self-efficacy is certainly worthy of consideration. Perhaps play therapy is what Plato (427 – 347 B.C.; n.d.) had in mind when he said, “You can discover more about a person in an hour of play than in a year of conversation.”

The third research question asked therapists who use play therapy with adult survivors to rate the effectiveness of play therapy with adult survivors. Eighty-one percent of the participants rated effectiveness of play therapy as 4 or 5, with 5 = Very effective. It might therefore be concluded that play therapy with adult survivors, as perceived by therapists who use it, is an appropriate approach to treating adult survivors. This conclusion offers hope to the therapists who work with adult survivors and to the survivors themselves. Future research will hopefully reaffirm this conclusion.

In this study, six themes were identified from the data by a panel of experts. Interestingly enough, all six of these themes have been identified and supported, albeit separately, by existing theories and research. Through this study, it became apparent that a model of play therapy for adult survivors must contain elements also critical in other modes of therapy. Since these themes will be used as the building blocks for a model for practice, each will now be discussed in relation to past and current literature and research.
Theme One: Non-threatening, Therapeutic Environment

This theme is supported by various other landmark works. In 1942, Carl Rogers authored the text, *Counseling and Psychotherapy*. He later proposed the core elements for client-centered therapy (1951), which have become standards for therapeutic relationships. Carl Rogers (1957) believed that when the core elements of empathy, unconditional acceptance, and congruence were present in a therapeutic relationship, personal growth would occur. Empathy means that you “lay aside your own views and values in order to enter another’s world without prejudice” (Rogers, 1980, p. 142). Unconditional acceptance refers to the counselor’s positive regard for the client; for who they are. The client is valued for his/her humanity, regardless of behavior (Mearns & Thorne, 2000). Congruence, according to Rogers, meant that the therapist was in the relationship “fully and accurately aware of what he is experiencing at this moment” (Rogers, 1961, p. 61). Several therapists in this study specifically mentioned the importance of the therapeutic relationship. Examples are as follows.

**Interviewee 2004-002:** “I focus on the therapeutic relationship. I work to establish that; trust.”

**Interviewee 2004-003:** “You need a safe environment where the person can come back repeatedly.”

**Interviewee 2004-006:** “Play therapy is about being vulnerable; it’s learning how to share; how to break bread with another. It’s learning how to cry with the client.”
Interviewee 2004-011: “I think you have to really understand the difficulties that people experience in their abusive situations and not try to push someone into doing something until they’re ready.” This therapist emphasized going where the client wanted to go; not where she thought they should go or be. That, she said, was honoring the client.

Interviewee 2004-012: “The key issues for using play therapy with adults are: (a) my relationship with them, and (b) the timing. There must be decent rapport and trust before I do much play therapy, although, I use humor from the start.”

Interviewee 2004-015: Referring to the Rose Garden exercise, this therapist explained, “It’s simple and non-threatening.”

Peplau (1952) and Sullivan (1953a, 1953b) each emphasized the therapeutic use of self in helping relationships. Both Peplau and Sullivan felt, as did Rogers, that the therapeutic relationship was imperative if the client was to make changes in their lives and grow from the experiences. Hildegard Peplau was a psychiatric nurse who delineated the therapeutic nurse-client relationship in four stages. The first, or orientation phase, is when the client seeks help. An empathetic and accepting attitude promotes trust. Next, the client’s strengths, needs, stressors, and coping patterns are assessed. Client-based interventions are established. Active listening and collaboration with the client during the next phase, the Working Phase, promotes growth and self-confidence. The client’s understanding of symptoms and insight into the therapeutic and other interpersonal relationships is addressed. Evaluation allows the client and clinician to look at resolution of the presenting problem and the quality of current interpersonal relationships (Antai-Otong, 2003). Therapists in this study
were congruent with Peplau’s emphasis on the therapeutic relationship, including the establishment of trust as a basis for the therapeutic relationship and the process of addressing the past and other interpersonal relationships through analyzing the relationship with the therapist. A positive change in behavior and development of effective coping skills characterized the wisdom of the therapists in this study. Interviewee 2004-010 summed it up by saying, “I think that in many, many cases the adults have learned ways of adaptation and coping skills, some of which are not particularly healthy and that’s usually what brings them in. We’ll go back in the childhood and talk about issues.” Insight gained leads to resolution and the development of more effective coping skills.

Harry Stack Sullivan (1940) believed that personality development continued into young adulthood. The development of the self-concept was affected by positive and negative experiences with the mother figure in infancy. Peers and social relationships continued to shape the child and adolescent. Sullivan believed that by changing the patterns of responding or communication, the person could change. The therapist’s encouragement and acceptance instills hope in the client. Through the use of the therapeutic self, the therapist facilitates healthy interpersonal skills, assisting the client in separating the past from the present and thus developing a more effective and satisfactory interpersonal way of relating. Self-worth, self-esteem, and dignity are promoted (Antai-Otong, 2003). Sullivan’s interpersonal theory was identified by 18.9% of the therapists in this study as the developmental theory that influenced their practice.
In summary, the literature on therapeutic relationships (Carkhuff & Berenson, 1977; Combs, Avila, & Purkey, 1978; Hames & Joseph, 1980; Truax & Carkhuff, 1967) is rich in the underlying importance of trust between client and therapist and the importance of a warm environment that is conducive to disclosure. Therapists interviewed in this study echoed the importance of the therapeutic relationship, especially since adult survivors have learned to be cautious of trusting anyone. The therapists in this study reiterated the need for the therapist to be in touch with their own feelings and values and of accepting the client unconditionally. Please see excerpts of participants’ responses identified above, under Theme One.

Other studies supported this finding of mine in their studies that dealt with adult survivors specifically. In a study by Constable (1994), the process of recovery for adult survivors was examined and she reported the importance of a safe environment in facilitating memory of traumatic experiences. Morrison and Ferris (2002) applied Satir’s model of therapy to adult survivors of CSA. The Satir model enables the therapist to work with the client in attaining an inner congruence, leading to a new sense of freedom and improved quality of life. They stressed the importance of building trust and welcoming the client to a safe and confidential environment. The therapist works with the client to reframe the past, and in doing so, the client emerges as a more confident person.

Hutchinson (2003) specifically discussed how she used play therapy with DID clients, remarking that she did so only after establishing trust with the host personality. Throughout the works cited under Theme One and repeatedly echoed by the therapists in this study was the fundamental importance of establishing trust with
the client. Play therapy provides a safe exploration of a traumatic past (O’Connor, 1991, 2000; Ross, 1997, 2000; Schaefer, 2003; Simonds, 1994). Clients can experience, in the presence of a trusted therapist, the feelings and emotions associated with the trauma. Because they have learned that their therapist can be trusted, they are able to face their past, knowing that they are genuinely accepted and will emerge from the session(s) safely and with dignity (Schaefer, 2003; Simonds, 1994). Each therapist in this study clearly communicated their care and concern for their clients. Words and phrases such as ‘honoring’ (Interviewee 2004-004; Interviewee 2004-011), ‘sharing with the client’ (Interviewee 2004-006), and ‘right to heal’ (Interviewee 2004-012) were examples that clearly reflected the therapists’ respect and caring for their clients.

Theme Two: Desired Therapist Characteristics
(Preparation and Experience)

This theme in this study was supported by what Dottie Ward-Wimmer (2003, p. 9) wrote about when she said the following: “We must be playful, because we should not expect our clients to go anywhere that we won’t. But playfulness is not necessarily a universal trait.” She cites Schaefer and Greenberg (1997) and the Playfulness Scale developed by them. They list five characteristics: (a) fun-loving, (b) sense of humor, (c) silliness, (d) informality, and (e) whimsical. Ward-Wimmer suggests that any therapist who might be considering using play therapy with adults, should first assess his or her playfulness traits.

The Association for Play Therapy (2003) provides a list of criteria for therapists working with children, but no guidelines exist for education, practicum, and
supervision for therapists using play therapy with adults. One obvious recommendation is that guidelines be developed for play therapy with adults to include education, practicum, and supervision of therapists, ethical standards for practice, and a monitoring system to evaluate adherence to these guidelines and standards. The therapists who participated in this study contributed wisdom and a part of themselves in helping to identify therapists’ characteristics that are conducive to facilitating effective play therapy in adult clients. Personal attributes of compassion, a sense of autonomy, adventurous spirit, fun loving, a willingness to be vulnerable, a sense of humor, and excellent practitioner describe the therapist participants in this study. Their enthusiasm, commitment to their clients, and warm invitation to play, explore, and heal were obvious. Those who had used play therapy with children prior to using it with adults, in most cases, were certified in play therapy. The art and music therapists drew upon their preparation in the creative arts. Many had completed additional training in sand tray use. One therapist was certified in psychodrama and one in hypnotherapy. None, however, had a formal academic program that specifically addressed adult play therapy or treatment of adult survivors, in particular. The dialogue must begin!

Theme Three: Successful Techniques

Table 8 presents a frequency rating of techniques most frequently used by the therapists in this study. Journaling, followed by sand tray and art, was the most common. The literature is rich in the use of sand tray (Boik & Goodwin, 2000; Bradway & McCord, 1997; Carey, 1999; Griffith, 2000; Hunter, 1998; Jung, 1959; McNally, 2001; Mitchell & Friedman, 1994; Ryce-Menuhin, 1992; Steinhardt, 1998)
and art therapy (Brooke, 1997; Greenberg & van der Kolk, 1987; Johnson, 1987; Kelley, 1984; Waller, 1992) in treating victims of sexual abuse. I was unable to locate any empirical studies that specifically evaluated various play therapy techniques and their effectiveness with adult survivors.

Nor were any studies found that specified which technique to use when. What became apparent from the participants’ examples was a grouping of techniques, based on goal or intent. If the intent was to facilitate expression of feelings or experiences that the client could not verbalize, the creative strategies were employed; whereas the goal of anger management was generally met with more active interventions, such as throwing balls or breaking clay pots.

Theme Four: Developmental Perspective

By far, the most influential developmental theory that affected the practice of the therapists in this study was Erikson’s Psychosocial. Mahler’s Object-relations was a more distant second. A developmental perspective has become one of the main tenets of play therapy for children (Axline, 1947; O’Connor, 1991, 2000; Schaefer & Cangelosi, 1993; Schaefer & Carey, 1994). Several of the therapists in this study stressed the importance of doing a thorough developmental history on their clients. By noting developmental lags and significant events occurring during critical periods, the therapist is able to more fully understand and, in many cases, properly diagnose survivors of CSA. Play assessments obtained during sand tray or artwork may give the astute therapist valuable insight into the traumatic past of the client.
Gitlin-Weiner, Sandgrund, and Schaefer (2000) offer a detailed guidebook for assessing a child's development, social skills, and family patterns of interaction. No corollary for assessing adults was found in the literature.

Data from this study supported the necessity of a developmental history in all clients and provided the framework for utilizing a developmental perspective in planning the treatment strategy for facilitating resolution and growth in the adult survivor. As many therapists put it, the techniques they chose were based on the premise that returning to a time prior to abuse and then working through painful experiences in a progressive manner offered the client the best hope for recovery and healing.

Theme Five: Justification for Using Play Therapy

In this study, the rationale for using play therapy with adult survivors was based on the developmental stage at the time of abuse (discussed previously), the client’s inability to express feelings, poor self-esteem, lack of trust, and strong, though not necessarily effective, defenses. Play returns the adult to a time when, through play, he or she could reclaim a part of him or herself, and succeed in the play scenario, thus increasing a sense of individuation and positive self-esteem (Blatner & Blatner, 1997; Boik & Goodwin, 2000; Roth & Batson, 1997; Schaefer, 2003; Simonds, 1994).

Since these factors have been previously discussed, no further literature review seems necessary. Because no empirical studies to date have looked at the issues raised with this study, it is obvious that the need for further research is needed.
Theme Six: Spirituality

The therapists surveyed in this study of play therapy with adult survivors of CSA echoed the essence of mind, body, and spirit congruence. This echoes what Hecker (2001) reported in his interview with Dr. Charles Whitfield, expert clinician and researcher in the treatment of adult survivors of childhood trauma. Hecker (2001) asked Dr. Whitfield to explain the stages of recovery from trauma. Stage Zero is active illness. Stage One begins the recovery process; that is, coming to treatment. In Stage Two, the person works with childhood and other trauma. Stage Three recovery is a spiritual realization. Dr. Whitfield (1998) explains that by spiritual he is not referring to any organized religion, but rather “the deeper dimensions of our relationships with self, others, and the universe (Higher Power, God, or whatever term is most comfortable for the individual) (p. 363). Stage Three involves answering the questions of not only, “Who am I?” but “What am I doing here?” and “Where am I going?” (Hecker, 2001, p. 100)

The Significance of the Study

A significant finding in this study was that 81% of the therapists who completed the online survey and answered Survey Question 10 on perceived effectiveness of play therapy with adult survivors selected a 4 or 5 on a 5-point Likert scale. The scale ranged from 1 = Ineffective through 3 = Moderately Effective to 5 = Very Effective. This suggests a greater than moderate perception of effectiveness of play therapy in treating adult survivors by the therapists in this study. Because the sample was small, generalization to the general therapist community must be done with caution. However, it is encouraging that the therapists in this study responded as
they did. The adult survivor's early childhood is scarred by trauma. Play therapy appears to have the potential to facilitate early resolution and safe reconstruction of a healthy paradigm of self in the adult client.

Another significant finding was in the multitude of techniques identified by the therapists in this study. The need for a succinct understanding of play therapy techniques applied to therapy with adult survivors became evident. For example, journaling, a cognitive technique, was listed by 67.6% of the therapists in this study as a technique that they used with adult survivors. Although it is generally not considered a play therapy technique, it appears to be a technique commonly used with adult survivors.

This study on the use of play therapy with adult survivors was undertaken to begin the exploration into a treatment modality that might lead to more effective and quicker resolution of childhood trauma in the adult survivor. The complexity of a life scarred by childhood abuse does not have a simple fix. In the experience of the therapists in this study, the techniques that they listed were helpful in assisting the adult survivor in reaching resolution of trauma and healing. The five most frequently selected techniques were: (a) journaling, 67.6%; (b) sand tray, 62.2%; (c) art, 59.5%; (d) anger management, 54.1%; and (e) imagery, 54.1%. It is interesting to note that all but one participant selected more than one technique. It might be concluded that not all techniques work for therapist and client and that flexibility in the choice of techniques may afford a better opportunity for success in treatment. The answer is in future research. It may be that a combination of play therapy techniques, along with verbal processing, will become the standard of treatment for adult survivors in the
near future. What is significant here is that support has been established for the use of play therapy and other (journaling) techniques in treating adult survivors. Even the therapists who declined participation because they did not meet participant criteria expressed support for the use of play therapy with adult survivors. This suggests a readiness in the field to consider play therapy as a viable approach with adult survivors.

Perhaps of greatest significance in this study's findings are the six themes that emerged from the analysis of the qualitative interview data. These six themes, which are: (a) non-threatening, therapeutic environment; (b) desired therapist characteristics; (c) successful techniques; (d) developmental perspective; (e) justification for using play therapy techniques; and (f) spirituality, provided the building blocks for proposing a model for practice in treating adult survivors of CSA. As they have been discussed under the Phase 3 data analysis section and are again discussed under the proposed model, discussion here is deferred. What is important to remember is that up to this point, no model or theory existed on the use of play therapy techniques with adult survivors; although recently, practitioners have shared their clinical wisdom, providing valuable suggestions and guidelines (Brooke, 2007; Carey, 2006; Corey, 1991; Glover, 1999; Hagood, 2000; Kellermann & Hudgins, 2000; Malchiodi, 2005; Sanderson, 2006; Schaefer, 2003). Therapists, as reported in the discussion of the interviews, gave examples of how they used play therapy techniques with their adult survivor clients. Support has been established for the use of play therapy with adult survivors. The time has come to formalize this treatment modality. Thanks to the therapists in this study and others who have pioneered using
play therapy with adults (see, in particular, Schaefer's book, *Play Therapy With Adults*, 2003), an exciting movement has begun.

In summation, this preliminary study draws attention to the need for further exploration of play therapy as an effective treatment modality for adult survivors of CSA. The cases reported by the therapist participants in this study are testimonials to the effectiveness of this choice of therapy approach. Repeatedly, the value of play therapy used to assist the client to express his or her anger, feelings, and other emotions dominated the wisdom and experience shared by practitioners in the field. Only one participant initially denied the use of play therapy with adult survivors, but later admitted that she used play therapy techniques in the broad sense of the word. Interestingly enough, this participant went on to rate the effectiveness of play therapy with adult survivors as "very effective." The remaining 20 participants graciously gave of their time to support an approach that they had learned through experience to be a path through the abuse jungle. The compassion, love, and understanding of all of the participants for their clients are remarkable and noteworthy.

Certainly the value in finding an avenue for uncovering a horrendous hidden past that play therapy may afford is a worthy pursuit. The long-term effects of CSA were discussed in chapter 2 and need not be repeated here, but suffice it to say that in cost alone, the price to the client, family, and society is astronomical. The effects on the body, mind, and spirit are beyond comprehension. A treatment approach that identifies and assists in healing is priceless. We must continue to research the use of play therapy with adult survivors for clients', families', and society's well-being and survival.
Limitations of the Study

A limitation of this study was the small sample size for the quantitative data analysis. Given the originality of the topic, it is not surprising that many potential therapist participants excused themselves from the study because they did not fit the criteria for participation. Caution is thus exercised in generalization of the quantitative data results. However, the richness of the qualitative interviews from knowledgeable and experienced therapists who use play therapy techniques in working with adult survivors of CSA provided an informative blueprint from which a model for practice might be generated.

Since many of the respondents in this study were registered play therapists, bias in the use of play therapy techniques must be considered. This study focused on the therapists’ perceptions rather than the clients’. Therefore, it is not known how clients perceive the effectiveness of play therapy techniques in resolving childhood trauma. Future research must address the client’s perceptions. Also, age, race, ethnicity, and gender of both client and therapist need to be addressed. This was not done in this initial study. Do these demographic characteristics require different techniques?

Finally, since this initial study focused only on therapists’ perceptions of effectiveness of play therapy with adult survivors, it is not known if other approaches are similarly effective in trauma resolution and cost-effective treatment.

Implications for Practice: A Proposed Model

As just stated in the discussion of the significance of this study’s findings, there has not been a theory or model for practice using play therapy techniques for adult survivors of CSA. However, therapists across the country are using play
therapy techniques with their adult survivor clients. It would seem most appropriate that a model for practice be proposed, so that the formal process of theory development can begin. One characteristic of a profession is that its members are guided in their practice by theory (Barger, 2006; Kearney, 2001; Tomey & Alligood, 1998; Wickenden, 2006). With this in mind, data obtained from this study, in particular, the six themes identified in the qualitative data analysis, are used here as the building blocks for the development of a model for practice.

A conceptual model is a representation of related concepts, with preparatory beliefs and assumptions. It provides a framework upon which a theory, tested and supported by empirical research, may be developed (Tomey & Alligood, 1998). In his text on families, Kenneth Davis (1996) offers a model for helping families that includes concepts, techniques, and guidelines. Following his format, basic concepts have been defined here as they apply to this proposed model for treating adult survivors. Play therapy techniques for use with adult survivors are those that were identified by participants in this study. A serendipitous finding in this study was the choice of technique based on intent or goal in treatment. If the intent or goal was to assist the client in expressing feelings or experiences, therapists generally chose the creative arts strategies. If the intent or goal was for the client to express and/or manage anger, the more active, physical strategies were chosen. Further research is needed in this area. Guidelines for therapist preparation have been suggested. It is hoped that this proposed model will be examined, modified, and tested by practitioners and researchers as additional research contributes to its future development.

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Beliefs

This proposed model is based on the following two beliefs. They were derived from participant responses and the work of Dr. Whitfield (1998).

It is the belief that:

1. The person (client) is a holistic being, having a mind, body, and spirit. Feelings and emotions are a part of the entwined holism (Interviewee 2004-006; Interviewee 2004-009).

2. Healing of mind, body, and spirit is possible, no matter how much trauma the person (client) has experienced (Interviewee 2004-006).

Rationale for Beliefs

Dr. Charles Whitfield (1998) views trauma as a harmful event that affects the total person. Therapists in this study clearly voiced the belief in the mind, body, and spirit connection. The resiliency of survivors was echoed by the therapist who said, “These people are survivors. They have learned to cope. They may be poor coping tools, but they figured it out on their own” (Interviewee 2004-003). One of the six recurring themes identified from the analysis of qualitative data in this study was the concept of spirituality. The mind and body effects from childhood sexual abuse have been well established in the literature and reinforced by this study’s participants. Clients present for therapy with a variety of emotional and physical problems. See Table 7 for a list of mental and emotional problems.
Assumptions

While an assumption is often referred to that which is accepted as fact, despite proof, it is used here to mean statements of postulates gleaned from participants’ statements and supported by theoretical formulations. An example is the assumption, suggested by participants in this study, that childhood sexual abuse alters normal development. This is supported by Erikson’s (1963) development theory that a person progresses through various stages in their development, and that if the task for that stage is unmet, further progression is adversely affected.

The assumptions for this model are:

1. Healing the effects of trauma is a process. It takes time (Interviewee 2004-001; Interviewee 2004-003).


4. Therapy for the adult survivor requires a skilled therapist, educated, and supervised in trauma recovery work (Interviewee 2004-001; Interviewee
5. It is essential that the therapeutic environment be conducive to a safe exploration. This requires that the client trust the therapist. The therapeutic relationship must work for both client and therapist (Interviewee 2004-002; Interviewee 2934-003; Interviewee 2004-006; Interviewee 2004-011; Interviewee 2004-023; Interviewee 2004-015).

Rationale for Assumptions

Adult survivors of childhood abuse have had years of coping with a painful and often hidden past. Although payment for therapy may make a quick fix desirable, the survivor of CSA must revisit his or her traumatic past, learn to trust, and forgive self before healing can begin. Erikson (1963) believed that a person must progress through a series of stages, each with its own developmental task. Trust is the first developmental task to be mastered. Adult survivors learn that they cannot trust significant persons in their lives. Therefore, developing a trusting therapeutic relationship is paramount in order for the work of recovery, healing, and growth to take place. Because the usual pattern of development has been altered, the adult survivor must, in a sense, begin, regardless of age, at the point where normal development was curtailed. Play therapy has the distinction of bringing the adult back to that arrested or altered developmental stage. Several of the therapists in this study stressed the importance of a developmental history as an essential component of the assessment process. Often, a client presents in therapy for a seemingly unrelated
issue/concern, but the astute therapist, conducting a thorough developmental assessment, may discover a horrible secret.

The literature and the therapists in this study revealed the multiple presentations that adult survivors bring to therapy, the health care system, and even the legal system. For this reason, the complexity of the adult survivor profile requires therapists, not only knowledgeable in the basics of the therapeutic relationship, but skilled in trauma theory and recovery work. The therapist working with adult survivors needs to be in tune with his or her own issues (Herman, 1992; Whitfield, 1998). And therapists who choose to use play therapy techniques with their clients are also asked to assess their own playfulness (Ward-Wimmer, 2003), being that such characteristics as humor, fun-lovingness, and one who enjoys the whimsical are part of what makes play therapy successful.

Concepts

A concept is an idea, mental image, or generalization. The following concepts are defined and presented as they apply to this model. Their definition is a collective consciousness and generally accepted terminology, as in the case of coping skill.

**Adult survivor**: The adult survivor is one who has been traumatized in childhood through physical, emotional, verbal, and/or sexual abuse. In addition to the therapists in this study, several authors have contributed to this broad definition of adult survivors of CSA (Briere, 1996; Davis, 2005; Draucker, 1998; Duncan, 2004; O'Connell Higgins, 1994; Ross, 2000; Roth & Batson, 1997; Schaefer, 2003; Simonds, 1994).
**Coping skills:** Coping skills are the ways in which a child learns to withstand childhood abuse. They carry into adulthood and may be ineffective in reducing the anxiety of everyday living.

**Play therapy techniques:** In this model, suggestions are offered for experiential strategies that allow the client to express feelings and emotions, as well as explore past traumatic experiences. These techniques include sand tray, art, journaling, drama, dance and movement exercises, and the use of toys, puppets, and animals. Anger management techniques are also included in this broad category. This term is broadly defined by the therapists in this study’s response to the request to identify the play therapy techniques that they used with adult survivors. It is hoped that as the exploration of the use of play therapy with adult survivors continues, a clear and concise definition will emerge. For now, I would like to suggest that play therapy techniques, as they apply to adult survivors, remain broad so that they encompass a variety of approaches aimed at facilitating the adult survivor’s expression of feelings, emotions, experiences, and experiences.

**Adult survivor therapist:** This is one who is specifically educated and supervised in working with adult survivors. This too is a working definition, as the proposed model is further examined and tested.

**Interrelationship Among Concepts**

A practice model must include the client, the therapist, and the treatment approach or strategy (Davis, 1996; Tomey & Alligood, 1998). Therefore, the client (adult survivor), the therapist (adult survivor therapist), and the treatment (play
therapy techniques and coping skills) are thus defined and interrelated. It serves to explain who does what to whom and how.

Recommendations for Practice

Although participants in this study were not asked to offer a model for practice, I would like to utilize their suggestions for what a therapist working with adult survivors should possess and have as preparation in making the following suggestions. It is suggested that the therapist would undergo an educational program that includes (a) trauma theory; (b) self-exploration; (c) practicum that includes a developmental history taking; and (d) supervised practicum, utilizing directive and non-directive play therapy interventions. It is suggested that the therapist have a minimum of 2 years’ experience before entering this specialized program. This is to gain experience and confidence as a therapist before embarking on a less conventional journey; that is, play therapy with adult survivors. Because adult survivors can be found in any setting, the practicum should include a variety of settings with various clients.

Basic principles of teaching adult clients (Baumgartner, 2003; Elias & Merriam, 2005; Knowles, Holton, & Swanson, 2005), including the characteristics of adult learners: (a) autonomy and self-direction, (b) incorporation of life-experiences and knowledge into new learning, (c) goal-orientation, (d) relevancy orientation, (e) practical application, and (f) respect (Lieb, 1991), might be included in the therapist’s education since recovery for the client often involves learning new coping skills and new relationship skills. An assessment of the adult client’s predominant learning style – (a) visual, (b) auditory, or (c) kinesthetic and tactile (Rose, 1987) – would be
helpful in tailoring the method of presenting material to facilitate the learning process. Additionally, an assessment of concrete versus abstract learning perception and processing (Learning Styles, n.d.) might be included, as adapting to the client’s predominant perceptual mode might helpful in facilitating learning. Finally, the developmental history assessment should include an evaluation of the school experience. This may have implications for approaching a teaching session. Unpleasant school experiences in childhood may adversely affect adult learning and, therefore, warrants exploration.

The Association for Play Therapy lists specific criteria for therapists who wish to be certified in play therapy. Perhaps looking at these criteria and the criteria that the Association lists for play therapy supervisors would be an excellent place to start. The time has come for this proposed model to go forward with formal guidelines, principles, outcome goals, and strategies. Further research is needed to bring about this theory development, and practitioners must begin the dialogue.

Recommendations for Further Research

To date, only one innovative group of pioneers has shared their collective insights and practice strategies for the use of play therapy with adult clients. Please see Schaefer’s (2003) Play Therapy With Adults. Contemporary research focuses on specific treatment modalities rather than the broader category of play therapy with adults, and no studies were found specifically addressing play therapy with adult survivors of CSA or the specific assessment of adults for childhood abuse. Clearly, the need for further research and development of a practice model is evident. A conceptual model gives us a place to start, but a theory on therapy with adult
survivors of CSA is desperately needed. Only through additional research and a coming together of experts in the field can ethical guidelines be established for a practice model and theory development.

A retrospective study evaluating the effectiveness of various treatment modalities for adult survivors from both the client and therapist perspective might provide valuable insight and direction. Subsequent studies of therapy with adult survivors might compare client outcomes and client and therapist satisfaction using two or three different approaches, one of which is play therapy. Focusing on specific play therapy interventions for a given diagnosis requires additional research. Are there certain techniques that work better than others for the given diagnosis? One principle that needs to be tested is the use of directive play therapy when the intent is to facilitate expression of feelings, emotions, and/or experiences versus non-directive, client-led play therapy when the intent is to reflect or simply ‘be in the moment’. Future research needs to address gender, age, race, ethnicity, education, and socio-economic status of clients. Do these variables make a difference in selection of technique or outcome? More research is needed on therapist variables as well.

Considerable empirical data must be gathered to support future trends in treating the adult survivor. There is a danger, however, in fostering research and practice that is not ethically sound. No harm must come to the already traumatized survivor. For this reason, it is hoped that a board of experts and clients will come together to set the course for the future.
The reader is encouraged to continue the exploration begun with this initial study. The potential impact for recovery by the adult survivor mandates testing and refinement of the model herein presented.

**Discussion of Theme Analysis Process**

Two suggestions, based on feedback from the team members who participated in the theme analysis, are offered for analyzing qualitative research using the Theme Analysis for Word-Rich Data, developed by Cooper (2003). In this study, one of the team members was a psychologist with experience in treating abused clients. One of the other team members expressed an initial reluctance to disagree with the perceived expert. As the process continued, however, the reluctance was eliminated. To avoid a potential bias among team members, it is suggested that team members simply be introduced by first names, without any further personal information. The primary qualification for team members is that they be an independent thinker. It is not necessary to divulge any personal information, professional status, or experience during the introduction of members.

The second suggestion expressed by the team members was that having the question and response together on the cards interfered slightly with their ability to think creatively. They felt that having the question posted created its own category. They suggested that only the responses be placed on the cards. They all agreed, however, that they were able to complete the analysis satisfactorily, as they were able to ignore the categories suggested by the questions and to come up with new categories. These new categories or themes became the building blocks for the proposed model presented in this chapter.
Summary of Chapter 5

In chapter 5, conclusions of this study, along with the rationale for the conclusions, were presented. A conceptual model for treating adult survivors of childhood sexual abuse with play therapy techniques was offered. Recommendations were given for further study.

The results of this study suggest that play therapy is an effective treatment approach that enables adult survivors of CSA to resolve childhood trauma and participate actively in the healing process. Almost 65% (64.9%) of the therapists surveyed in this study used play therapy with adult clients. They rated the effectiveness of using play therapy with adult survivors as Very Effective (on a Likert scale where Very Effective was the highest rating).

The most common play therapy techniques were journaling, sand tray, art, anger management, imagery, role-play, and humor. Clients initially presented for depression, PTSD, sexual abuse, anxiety, DID, substance abuse, and eating disorders.

In analyzing the data from 21 in-depth interviews, six themes emerged, which were presented in this chapter as the building blocks for a model for play therapy with adult survivors. These building blocks or concepts were: (a) non-threatening therapeutic environment, (b) desired therapist characteristics, (c) successful techniques, (d) developmental perspective, (e) justification for using play therapy, and (f) spirituality.

Finally, the need for further research, including replication, the use of a larger sample, client variables, and testing of various techniques were suggested.
Adult survivors often bury the past; thus traditional adult talk therapy bypasses the trauma, perhaps burying it even more deeply. Through the use of play therapy techniques, the client and therapist may more safely explore the horrors of the past. In a time when cost-effective therapy is essential, the potential for a more efficient and thorough resolution and recovery is paramount. Real-case scenarios shared by the therapist participants in this study support the power to heal and the potential for growth when play therapy techniques are used with adult survivors.
E-MAIL NOTICE

Name of Potential Participant:

Hello! I am a doctoral student in Counseling Psychology at Andrews University and am researching the use of Play Therapy with Adult Survivors of Childhood Sexual Abuse. May I ask:

1. Do you currently use play therapy with adult survivors of childhood sexual abuse?
2. What percent of your practice is with adult survivors?
3. Would you be willing to complete a brief on-line survey?

If you answered, “Yes” to Questions 1 and 3, please read the attached informed consent letter and if you agree to participate, then click on the following website address to complete the short survey on-line: www.totalpersons.com

Thank you.

Mary J. Roehrig, MSN, MA, LPC
(231) 592-1054
Hello! I am a doctoral student at Andrews University in Counseling Psychology. Several weeks ago, I sent you an E-Mail asking if you would participate in a short survey. If you responded anonymously, thank you very much. Your input is valuable. If you forgot or missed that E-Mail, would you consider answering the survey now?

I am studying the Use of Play/Experiential therapy with Adult Survivors of Childhood Sexual Abuse. The survey is only 10 questions and shouldn’t take you long to complete. Even if you do not work with adults or use play/experiential therapy with Adult Survivors, you corresponding response would be appreciated.

If you would consider participating in a phone interview, I would welcome the opportunity to talk with you. The Survey has a space for you to indicate your willingness to participate in an interview. Please go to: www.totalpersons.com to reach my website. Click on the Therapist button to access the survey.

I am attaching the consent letter for your on-line participation. See below.

Thank you once again for your valuable input.

Mary J. Roehrig
(231) 592-1054

Andrews University
Department of Educational and Counseling Psychology

The Use of Play/Experiential Therapy with Adult Survivors of Childhood Sexual Abuse

Mary J. Roehrig, doctoral student in Counseling Psychology

Informed Consent Letter for Online Survey

The purpose of my doctoral dissertation is to explore the use of play/experiential therapy with adult survivors of childhood sexual abuse. As a therapist, your input is valuable in describing current treatment modalities. While no harm should result from this investigation, the potential development of a treatment model, based on what is currently utilized by practicing therapists may be beneficial to you in your practice. This is particularly important in a time when cost-effective treatment approaches are necessary. An approach supported by research as effective has the potential to offer your clients a resolution that may lead to a quicker and more enduring recovery process.

You will be asked to answer questions regarding your treatment approach to adult survivors, specific play/experiential therapy techniques that you might use, and judge their effectiveness. It will take approximately 15 minutes to complete the objective items.
Your identity will remain confidential. I ask only for demographic data for statistical purposes and in case I need to contact you for verification of information. Only generic client information will be included in study results and any publication. No client will be identified.

You may withdraw your participation at any time. There is no cost to you other than your valuable time. If you have any questions at anytime, you may reach me at: (231) 592-1054.

I understand the purpose of the study, the process, possible benefits, and that any questions that I have will be answered by Mary Roehrig. I further understand that my identity will be kept confidential and that I am under no obligation to participate. With this understanding, I voluntarily agree to participate.

Thank you.

Mary J. Roehrig
(231) 592-1054
APPENDIX B

CONSENT FORMS
Andrews University
Department of Educational and Counseling Psychology

The Use of Play Therapy with Adult Survivors of Childhood Sexual Abuse

Mary J. Roehrig, doctoral student in Counseling Psychology

Informed Consent

The purpose of my doctoral dissertation is to explore the use of play therapy with adult survivors of childhood sexual abuse. As a therapist, your input is valuable in describing current treatment modalities. While no harm should result from this investigation, the potential development of a treatment model, based on what is currently utilized by practicing therapists may be beneficial to you in your practice. This is particularly important in a time when cost-effective treatment approaches are necessary. An approach supported by research as effective has the potential to offer your clients a resolution that may lead to a quicker and more enduring recovery process.

You will be asked to answer questions regarding your treatment approach to adult survivors, specific play therapy techniques that you might use, and judge their effectiveness. It will take ½ to 1 hour of your time for the interview. Your identity will remain confidential. I ask only for demographic data for statistical purposes and in case I need to contact you for verification of information. Only generic client information will be included in study results and any publication. No client will be identified.

You may withdraw your participation at any time. There is no cost to you other than your valuable time. If you have any questions at anytime, you may reach me at: (231) 592-1054. You may also contact my academic advisor and dissertation chair, Dr. Nancy Carbonell at (269) 471-3472.

I understand the purpose of the study, the process, possible benefits, and that any questions that I have will be answered by Mary Roehrig. I further understand that my identity will be kept confidential and that I am under no obligation to participate. With this understanding, I voluntarily agree to participate.

Participant

Mary J. Roehrig, Investigator

Date

Date

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Andrews University  
Department of Educational and Counseling Psychology  

The Use of Play/experiential Therapy with Adult Survivors of Childhood Sexual Abuse  

Mary J. Roehrig, doctoral student in Counseling Psychology  

Informed Consent Letter for Online Survey  

The purpose of my doctoral dissertation is to explore the use of play/experiential therapy with adult survivors of childhood sexual abuse. As a therapist, your input is valuable in describing current treatment modalities. While no harm should result from this investigation, the potential development of a treatment model, based on what is currently utilized by practicing therapists may be beneficial to you in your practice. This is particularly important in a time when cost-effective treatment approaches are necessary. An approach supported by research as effective has the potential to offer your clients a resolution that may lead to a quicker and more enduring recovery process.  

You will be asked to answer questions regarding your treatment approach to adult survivors, specific play therapy techniques that you might use, and judge their effectiveness. It will take approximately 15 minutes to complete the objective items. Your identity will remain confidential. I ask only for demographic data for statistical purposes and in case I need to contact you for verification of information. Only generic client information will be included in study results and any publication. No client will be identified.  

You may withdraw your participation at any time. There is no cost to you other than your valuable time. If you have any questions at anytime, you may reach me at:  
(231) 592-1054. You may also contact my academic advisor and dissertation chair,  
Dr. Nancy Carbonell at (269) 471-3472.  

I understand the purpose of the study, the process, possible benefits, and that any questions that I have will be answered by Mary Roehrig. I further understand that my identity will be kept confidential and that I am under no obligation to participate. With this understanding, I voluntarily agree to participate.  

Thank you.  

Mary J. Roehrig  
(231) 592-1054
APPENDIX C

SURVEY INSTRUMENT
Play Therapy with Adult Survivors
Of Childhood Sexual Abuse Survey

I have read the informed consent letter and understand by completing the online survey and returning it, I am granting consent to my participation.

Directions: Please check the appropriate boxes or type in your answer for Questions 1 thru 7. More than one box may be check per question. For Questions 8 thru 12, please answer as completely as you wish. Thank you.

1. Do you currently use play or experiential therapy with adult survivors of childhood sexual abuse?

☐ Yes   ☐ No

2. What percent of your practice is with adult survivors?

☐ Less than 25%
☐ 25%
☐ 50%
☐ 75%
☐ 100%

3. What degrees do you hold?

☐ MD    ☐ EdD    ☐ DMin
☐ PhD   ☐ PsyD   ☐ MSW
☐ MSN   ☐ MEd    ☐ MA
☐ MFT   ☐ MDiv   ☐ MS
☐ EdS   ☐ Other

If other, list here:


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4. What licenses/certifications do you have?

☐ LP  ☐ CSW/CISW  ☐ LMFT
☐ LLP  ☐ LCSW  ☐ CAC
☐ LPC  ☐ RPT-S  ☐ Other

If other, please list here:

☐ Other

5. What is your predominant theoretical orientation?

☐ Behavioral  ☐ Rational-emotive
☐ Cognitive  ☐ Gestalt
☐ Humanistic  ☐ Other

☐ Psychoanalytical

If other, please list here:

☐ Other

6. Which of the following developmental theories most influences your practice?

☐ Psychoanalytical (Freud)
☐ Interpersonal (Sullivan)
☐ Psychosocial Development (Erickson)
☐ Object Relations (Mahler)
☐ Cognitive Development (Piaget)
☐ Moral Development (Kohlberg)
7. Which of the following would best describe your overall approach to therapy?

- [ ] Behavioral
- [ ] Experiential
- [ ] Cognitive
- [ ] Psychoanalytical
- [ ] Eclectic
- [ ] Interpersonal
- [ ] Expressive
- [ ] Other Please explain in the box below.

8. What is the most frequent presenting problems of adult clients with whom you use play or experiential therapy?

- [ ] Anxiety Disorders
- [ ] PTSD
- [ ] Depression
- [ ] Substance Abuse
- [ ] DID
- [ ] Victims of Sexual Abuse
- [ ] Eating Disorders
- [ ] Other

If other, list here:

9. What techniques/modalities do you use with adult survivors of childhood sexual abuse?

- [ ] Art
- [ ] Sand play
Music       Puppetry
Psychodrama   Therapeutic games
Role-play     Finger painting
Imagery       Physical activity
Humor        Anger management
Dance        Journaling
Other

Note: Anger management may include shredding paper, hitting a punching bag, throwing balls, etc.

If other, please list here:

10. On a scale of 1-5, with 1 = ineffective and 5 = very effective, how would you rate the effectiveness of using play therapy with adult survivors?

1  2  3  4  5
Ineffective  Moderately effective  Very effective

1  2  3  4  5

If you would consent to being interviewed via telephone, please list the following information so that I may contact you.

Name:_________________________________________________________

Phone: ( )___________________________________________________

E-Mail:_______________________________________________________
Best time to call to set up an interview:

Day of the week: ___________________________________________

Time frame: ___________________________________________

Do you prefer a phone call or e-mail contact to establish an interview time?

_____ Phone call

_____ E-mail

Thank you!
Introduction
Qualitative researchers often produce research data in the form of a verbatim record of participant dialogue captured during personal interviews or focus group participation. The recorded narrative is typically rich in expressions of opinions, attitudes, feelings, self-reported experiences, and the like. Analysis of this word rich data is often focused on uncovering common themes within the data.

Theme analysis of word-rich data is an adaptation of affinity analysis sometimes applied to word-rich data developed during brainstorming. The purpose of theme analysis is to summarize word-rich data collected during application of qualitative research methods (e.g. personal interviews or focus group dialogue). Theme analysis is a process for (1) uncovering common threads running through the data, (2) identifying representative comments illustrating or supporting each theme, and (3) identifying comments representing expressed diversity around each theme.

Analysis Team
In order to promote objectivity in the analysis process, a small team performs the analysis with help from a skilled facilitator. A skilled facilitator manages the analysis process performed by two or three independent thinkers (themers) with relevant content and process knowledge but little stake in the specific outcomes (themes).

♦ Themers – Two or three independent thinkers with relevant content and process knowledge but little stake in specific outcomes (themes)
♦ Facilitator – Skilled facilitator with no stake in the outcomes (themes)
♦ Recorder – Skilled recorder to capture themer comments and make in-process notes on the analysis process

Prep Steps
The following steps, usually performed by the researchers, prepare the data for analysis by the independent analysis team.

1. Transcribe the dialogue verbatim.

2. Identify separate comments in the transcript. Delimit comments by participant voice and sequence within the dialogue.

3. Place each comment on a 5 by 6 card or sticky note. A comment deemed possibly relevant to multiple themes may be placed on multiple cards – one card for each comment. Place the cards in chronological order. Number the sequenced cards from 1 to N.
4. Sort cards into preliminary clusters (categories) by topic, question, or some other relevant scheme.

5. Place cards on a clear, accessible, vertical wall – grouped according to preliminary topics or categories. Here sticky putty or post-it notes are helpful.

**Theme Analysis Steps**
The following steps are performed by the themers and guided by the facilitator:

1. **Initial Clustering:** With guidance about process from the facilitator, themers quietly walk about the room reviewing the walled cards – looking for common themes among them.

   Themers may move individual comment cards to form new clusters perceived by the themers to be related. Themers may also place replicates into different clusters and may also create sub-groups within a cluster.

   Themers review and move cards *silently* – neither discussing their logic nor questioning that of others. Cards may be moved back and forth by different themers.

   If a themer disagrees with a placement of a card, she may move the card to an existing cluster or sub-group or create a new cluster or sub-group.

   Facilitator guides the process. The facilitator will end this process when clusters stabilize i.e. little or no residual card movement or replacement.

2. **Final Clustering:** Themers disclose and inquire as to the logic of their clustering choices – working toward agreement regarding final card placements. Facilitator guides the process. Recorder captures notable aspects of dialogue.

3. **Name Themes:** The themers consider each cluster as representative of a yet un-named theme and each emergent sub-grouping an un-named sub-theme. The facilitator facilitates the process of creating and posting theme headings for each cluster and sub-group. Recorder captures notable aspects of dialogue.
4. **Identify Quotes:** Themers identify quotes representing each theme and sub-theme, as well as quotes expressing the breadth of participant diversity with respect to each theme or sub-theme. Facilitator guides the process. Recorder captures notable aspects of dialogue.

5. **Relate Clusters:** Themers identify and analyze inter-relationships among the themes. Facilitator guides the process. Recorder captures notable aspects of dialogue.

6. **Debrief Session:** The facilitator debriefs the themers to uncover lessons learned from the theme content and about the theming process. Recorder captures notable aspects of dialogue.

**Outcomes**

1. A set of named themes (and perhaps sub-themes) summarizing the word-rich data

2. Representative participant comments illustrating or supporting each theme and sub-theme

3. Representative participant comments illustrating expressed diversity around each theme

4. Recorded notes on theme logic, inter-relationships, and lessons learned

**Next Steps**

1. Validate the themes and sub-themes by asking the original subjects to review and comment on each theme and sub-theme. The primary question here is: In what ways do the participants agree with the themes and in what ways do they disagree?

2. Validate the themes and sub-themes by asking independent knowledgeable experts to review the data and themes. The primary question here is: In what ways do independent experts agree with the themes and in what ways do they disagree?
Play Therapy with Adult Survivors
Interview Record

Interviewee: ___________________________ Date: ________________________
Phone: ___________________________ E-Mail: ___________________________

<table>
<thead>
<tr>
<th>Target Questions</th>
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<tbody>
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<td>How did you come to use play therapy techniques with adult survivors?</td>
<td></td>
<td></td>
</tr>
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<td>How do you determine which clients you will use play therapy techniques with?</td>
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<tr>
<td>Would you describe a session where you used play therapy techniques?</td>
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<table>
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<tr>
<th>Why did you choose to use this technique at this time?</th>
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<td></td>
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<tr>
<td>Are there other techniques that you frequently use?</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>Is there anything else that you would care to share with me about play therapy with adult survivors?</td>
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Comments:
**Play Therapy with Adult Survivors**  
**Interview Record**

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<td>How did you come to use play therapy techniques with adult survivors?</td>
<td>I work in the Trauma Program at Forest View. I learned from Dr. Ross and Melissa Cauldwell. She is the Clinical Program Director at Timberlawn. The Program is based on Dr. Ross', Trauma Model. I started with leading an anger management group. Margo, a therapist, that used to work here, would go into the gym with the clients and throw clay balls. We also have an art therapist here. I picked up some techniques from her.</td>
<td>Trauma Program</td>
</tr>
</tbody>
</table>

| How do you determine which clients you will use play therapy techniques with? | The client must be ready. I do Trauma Consultations. If I have a client who is stuck in depression, I go to the anger. I try to get them in touch with what their body is feeling. If they can't express themselves, we might go into the gym. I will have them start by throwing the clay balls at the wall. Then I have them talk about what they are feeling. | Client must be ready. |

- get in touch with what their body is feeling  
- can't express themselves
| Would you describe a session where you used play therapy techniques? | I had a female client who was depressed, but she was stuck and couldn’t express her feelings. We went into the gym and she started throwing the balls. I asked her what she was feeling. She was afraid and angry at her mother for not protecting her. As she verbalized this, she threw the balls with more force and raised her voice; yelling; and then sobbing. Afterwards, we processed what had taken place – how it was not her fault. I would have her say, “I’m a good person. It was not my fault.” Over and over. Another time, I had a male client throw the balls, while he said, “It hurts me that I couldn’t make you love me, Dad. Dad, I needed you to love me.” | stuck and couldn’t express feelings |
| Why did you choose to use this technique at this time? | Because she couldn’t express her anger/ her feelings. She couldn’t talk about it. | Couldn’t express feelings. Couldn’t talk about it. |
| Are there other techniques that you frequently use? | Yes, I use family sculpting. We talk about issues in the present; how you would like your family to be. | Family sculpting |
| Is there anything else that you would care to | Yes, trauma can be from physical abuse, sexual, verbal or | Trauma can be physical abuse, sexual, verbal or |
| share with me about play therapy with adult survivors? | verbal, or emotional abuse. It can also be emotional or physical neglect. It could be trauma from war. It could be abandonment. In talk therapy, a person is on a treadmill. Using these techniques can wipe away two or three sessions. It helps people to express themselves, when they cannot do so verbally. | emotional. It can also be neglect. War Abandonment Using these techniques can wipe away 2-3 sessions. Helps them to express themselves when they cannot verbally. |

Comments:
Play Therapy with Adult Survivors
Interview Record

Interviewee: 2004-002 Pilot

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<tbody>
<tr>
<td>How did you come to use play therapy techniques with adult survivors?</td>
<td>I use visualization exercises for clients with sexual abuse problems to access their historical experience. I don’t really have a theoretical approach per say, but I focus on a lot of affective processing. The therapeutic relationship is very important and I work to establish that; trust. I focus on the therapeutic relationship as a tool. I do family therapy and play associated with that.</td>
<td>Visualization, Affective processing, -therapeutic relationship, - trust, - family therapy, - play associate with family therapy</td>
</tr>
<tr>
<td>How do you determine which clients you will use play therapy techniques with?</td>
<td>I thinking of someone that I have been working with. I open the session with small talk and what is going on. This client</td>
<td></td>
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</tbody>
</table>
came in and was superficial for awhile. I asked her what was going on? Based on our relationship, she realized that she was avoiding talking about things that we had previously identified. We focused on what was going on right then between her and I. She said she was embarrassed to talk about it. We talked about how what had happened affected getting close in a relationship now. I have warm afghans that clients can wrap up in. don’t know if that is play therapy, but I want them to feel comfortable. I have candy in my office and a warm, inviting atmosphere.

<p>| Why did you choose to use this technique at this time? | I focus on the therapeutic relationship. Previous relationships affect present relationships and I use the therapeutic relationship as a tool for looking at the past and healing it. | - therapeutic relationship as tool for healing past |
| Are there other techniques that you frequently use? | When I was in private practice, I sometimes had lower functioning clients. They weren’t always able to express themselves in words. I used art therapy, coloring, drawing, games. I inherited my parents therapy dolls. | Lower functioning clients can’t express selves in words. Art therapy Coloring, drawing Games Therapy dolls |</p>
<table>
<thead>
<tr>
<th>They are doing missionary work and so I have their therapy dolls.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there anything else that you would care to share with me about play therapy with adult survivors?</td>
</tr>
<tr>
<td>No, I don’t know if I really use play therapy or not. I mainly focus on the process of the therapeutic relationship and what is going on with the client. I guess maybe I do do some. I just didn’t think of it as play therapy.</td>
</tr>
</tbody>
</table>

Comments:
### Play Therapy with Adult Survivors
#### Interview Record

**Interviewee:** 2004-003 Pilot

**Date:**

**Phone:**

**E-Mail:**

<table>
<thead>
<tr>
<th>Target Questions</th>
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<th>Code and Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>How did you come to use play therapy techniques with adult survivors?</td>
<td>Well, I taught classes for all ages from kindergarten all the way to, my oldest student was 90, and I taught, I mean she was 100, and I taught art, and some of the things that I saw in my classes, no matter what age they were negative comments; so much feedback from someone else's opinion about what they couldn't do. A friend of mine said, you already do art, why don't you go to school to be an art therapist, so I did. There was an opening for an Art Therapist and so I applied and here I am. I learned about Dr. Ross' Trauma Model and the person's inability to express some feelings.</td>
<td>Art Therapist, Trauma Model - inability to express feelings</td>
</tr>
<tr>
<td>How do you determine which clients you will use play therapy techniques with?</td>
<td>Trauma patients have issues with relationships, grief and loss, anger — we do specific things to get their body involved, like movement therapy, anger work. Even though they may feel the anger</td>
<td>Trauma clients</td>
</tr>
</tbody>
</table>
in their body, they can not express it verbally. Art therapy is available to all the patients, but I work primarily with trauma patients.

<table>
<thead>
<tr>
<th>Would you describe a session where you used play therapy techniques?</th>
<th>I am thinking of a patient who was abused and expressed being angry at her mother. I asked her to draw her anger. I might use color. For example, I might ask you what is your favorite red food? You would say, ‘strawberries’. You have eliminated other red foods like apples. There is something very particular about strawberries.. When I ask you why, you would say, “because it reminds me of walking in a field with my mom.” We would then talk about that.</th>
<th>Angry client drew anger.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why did you choose to use this technique at this time?</td>
<td>Trauma patients say, “I don’t feel my feelings.” They may not be able to say what they feel, but they can draw it.</td>
<td>Draw feelings</td>
</tr>
<tr>
<td>Are there other techniques that you frequently use?</td>
<td>Any type of therapy that involves the creative side is set up with 2,050 choices. Play therapy, art</td>
<td>Creative side of brain</td>
</tr>
<tr>
<td>Is there anything else that you would care to share with me about play therapy with adult survivors?</td>
<td>It is a process. You can’t fix eighteen years of trauma in a month. These people are survivors. They have learned to cope. They may be poor coping tools, but they figured it out on their own. Trauma intensifies negative feeling from others to a point where it interferes with regular development. You need a safe environment where the person can come back repeatedly. You can’t eat an elephant in one bite and you can’t undo or fix years of trauma quickly, but the play therapy helps the client to get there faster.</td>
<td>Gradual process of recall and processing feelings Survivors Ineffective coping Interference with normal development Safe environment Recovery quicker with play therapy</td>
</tr>
</tbody>
</table>

Comments:
Play Therapy with Adult Survivors
Interview Record

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</tr>
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<tbody>
<tr>
<td>How did you come to use play therapy techniques with adult survivors?</td>
<td>Well, I had a client who came in and she was in her anger at the time. She said she wanted to rip my office apart. And, I thought, what could we use as an alternative? So, we went in to the playroom and made playdoh balls. We made an image of the abuser and let her throw the balls at it. Boy, was that effective! A lot of it is intuitive; it just comes around. Play is something that adult survivors haven’t gotten.</td>
</tr>
<tr>
<td>How do you determine which clients you will use play therapy techniques with?</td>
<td>Well, if you listen to a client, they will tell you what they need. It’s probably what I do with all my clients. I think of it as empowerment. I teach them how to take control of their anger; how to be self-caring. I teach them how to find joy in their life.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code and Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angry client</td>
</tr>
<tr>
<td>Playdoh balls</td>
</tr>
<tr>
<td>Survivors haven’t played.</td>
</tr>
<tr>
<td>Client tells you.</td>
</tr>
<tr>
<td>Empower clients to take control of anger</td>
</tr>
<tr>
<td>Self-caring</td>
</tr>
<tr>
<td>joy</td>
</tr>
<tr>
<td>Would you describe a session where you used play therapy techniques?</td>
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<tr>
<td>Why did you choose to use this technique at this time?</td>
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<tr>
<td>Question</td>
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<tr>
<td>Are there other techniques that you frequently use?</td>
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<td>Is there anything else that you would care to share with me about play therapy with adult survivors?</td>
</tr>
</tbody>
</table>

Comments:
### Target Questions Response Code and Comments

<table>
<thead>
<tr>
<th>How did you come to use play therapy techniques with adult survivors?</th>
<th>Well, partially because of the training at Andrews; although I don’t think they had a course specifically in play therapy in adults. But, finally, I did my work at Eagle Village, where they did live interventions – they call them interventions.</th>
<th>Eagle Village interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>How do you determine which clients you will use play therapy techniques with?</td>
<td>Clients don’t necessarily come for sexual abuse matters. It comes out in the process. Sometimes, talking just doesn’t work and so, using experiential types of interventions does. I just use them when a client is stuck.</td>
<td>Talking doesn’t work, so Use experiential interventions When a client is stuck</td>
</tr>
<tr>
<td>Would you describe a session where you used play therapy techniques?</td>
<td>See the board over there? It is a table with rollers underneath them. They have to discuss the rollers as being things</td>
<td>Table with wheels Rollers represent help</td>
</tr>
<tr>
<td>Question</td>
<td>Answer</td>
<td>Technique</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Why did you choose to use this technique at this time?</td>
<td>I used this technique at Eagle Village and it worked, so I just continue to use it. It can be a very powerful . . . awareness.</td>
<td>Awareness</td>
</tr>
<tr>
<td>Are there other techniques that you frequently use?</td>
<td>Other helpful techniques to use include using a puzzle. You dump it out on the table and say, “This is your life” and you ask them to put it back together. If you don’t have the picture to look at, it helps them to problem-solve. Ask them what their process would be? Most always they will say do the border first.</td>
<td>-puzzle</td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
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<td>------------------------------------------------------------------------</td>
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<tr>
<td>I also use art. I have clients draw pictures of themselves and what they are feeling.</td>
<td>Art</td>
<td></td>
</tr>
<tr>
<td>Is there anything else that you would care to share with me about play therapy with adult survivors?</td>
<td>Just that it works.</td>
<td></td>
</tr>
</tbody>
</table>
**Play Therapy with Adult Survivors**

**Interview Record**

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<tr>
<td>How did you come to use play therapy techniques with adult survivors?</td>
<td>I see clients at Forest View and have worked with Dr. Ross there. He specializes in victims of sexual abuse. Dr. Ross' and Dr. Charles Whitfield talk about the Trauma Model. They use play therapy at Forest View. Adults who have been sexual abused as children have attachment issues. The [child’s] developmental stage stopped at the time of abuse. I give them an object, a talisman, if you will, to represent where they were at the time of abuse. They keep it with them. It serves to ground them . . . you build on trust and go to object permanence.</td>
<td>Trauma Model Play therapy Developmental stage stoppage Representative object Trust Object permanence</td>
</tr>
<tr>
<td>How do you determine which clients you will use play therapy techniques with?</td>
<td>One therapy does not fill all for adults with [childhood] sexual abuse. If they are dissociating, you have to design your therapy to the level that they are at. You have to listen with</td>
<td>Therapy at client’s level of functioning (particularly in dissociation)</td>
</tr>
<tr>
<td>Question</td>
<td>Client's history</td>
<td>Table 1: Client's History</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------</td>
</tr>
</tbody>
</table>
| Would you describe a session where you used play therapy techniques?    | I have two clients that I have meals with. We sit on the floor and eat. Then, I read them a story. You can't touch them, but I have a rocking chair and they may sit in the rocking chair and I will rock the chair. I may give them a blanket to feel warm. I do not hold clients. I use transference. You go through the whole objects relation process. So, the way I touch them is that I rock them. I give them a blanket or I put a pillow against them so that they feel my warmth, but it's not me. It's that I am rocking the chair, but they have a blanket around them. I am sitting beside them. | Eat with client  
Sitting on the floor  
Read a story  
No touching, but my use rocking chair.  
Blanket for warmth.  
Transference  
Objects relation process |
| Why did you choose to use this technique at this time?                  | Sexual abuse occurred at an early developmental stage. The client did not learn to trust and needed to learn self-nurturing.                                                                                           | Early developmental stage abuse  
Lack of trust  
Unable to nurture self |
| Are there other techniques that you frequently use? | Play therapy can be anything from psychodrama to art therapy to anger work with clay balls and throw them at the wall. I have used clay work. [There is] painting and finger painting, role-play, sand, videos, and stories. | Psychodrama | Art therapy | Anger work with throwing balls. | Clay work | Painting | Finger painting | Role play | Sand, videos, and stories |
| Is there anything else that you would care to share with me about play therapy with adult survivors? | The work has to include the spiritual component; a balance of mind, body, spirit. Dr. Whitfield talks about we have to first do work in our head and our heart. Play therapy is about being vulnerable; it's learning how to share; how to break bread with one another. It's learning how to cry with the client. Therapists have to be doing their own work and having their own support system or they're going to get involved in an area where they are projecting their own feelings on to the client and it is going to be a disaster for everyone. I can't believe that many of the professional training centers do not make it mandatory that | Spiritual component | Head and Heart | Vulnerable | Sharing | Cry with client | Therapists do own work |
| you have to have had X number of hours of individual and group therapy yourself. |

Comments:
Play Therapy with Adult Survivors  
Interview Record

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<td></td>
</tr>
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<td>How do you determine which clients you will use play therapy techniques with?</td>
<td>The client must be ready. I do Trauma Consultations. If I have a client who is stuck in depression, I go to the anger. I try to get them in touch with what their body is feeling. If they can’t express themselves, we might go into the gym. I will have them start by throwing the clay balls at the wall. Then I have them talk about what they are feeling.</td>
<td></td>
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<td>Question</td>
<td>Answer</td>
<td></td>
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<td>Would you describe a session where you used play therapy techniques?</td>
<td>I had a female client who was depressed, but she was stuck and couldn’t express her feelings. We went into the gym and she started throwing the balls. I asked her what she was feeling. She was afraid and angry at her mother for not protecting her. As she verbalized this, she threw the balls with more force and raised her voice; yelling; and then sobbing. Afterwards, we processed what had taken place – how it was not her fault. I would have her say, “I’m a good person. It was not my fault.” Over and over. Another time, I had a male client throw the balls, while he said, “It hurts me that I couldn’t make you love me, Dad. Dad, I needed you to love me.”</td>
<td></td>
</tr>
<tr>
<td>Why did you choose to use this technique at this time?</td>
<td>Because she couldn’t express her anger/ her feelings. She couldn’t talk about it.</td>
<td></td>
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<td>Are there other techniques that you frequently use?</td>
<td>Yes, I use family sculpting. We talk about issues in the present; how you would like your family to be.</td>
<td></td>
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<td>Is there anything else that you would care to share with me about play</td>
<td>Yes, trauma can be from physical abuse, sexual, verbal, or emotional</td>
<td></td>
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<td>therapy with adult survivors?</td>
<td>abuse. It can also be emotional or physical neglect. It could be trauma from war. It could be abandonment.</td>
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<td>-----------------------------</td>
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<td></td>
<td>In talk therapy, a person is on a treadmill. Using these techniques can wipe away two or three sessions. It helps people to express themselves, when they cannot do so verbally.</td>
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Comments:
**Play Therapy with Adult Survivors**

**Interview Record**

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<th>Response</th>
<th>Code and Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>How did you come to use play therapy techniques with adult survivors?</td>
<td>I use visualization exercises for clients with sexual abuse problems to access their historical experience. I don't really have a theoretical approach per say, but I focus on a lot of affective processing. The therapeutic relationship is very important and I work to establish that; trust. I focus on the therapeutic relationship as a tool. I do family therapy and play associated with that.</td>
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<tr>
<td>How do you determine which clients you will use play therapy techniques with?</td>
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<tr>
<td>Would you describe a session where you used play therapy techniques?</td>
<td>I thinking of someone that I have been working with. I open the session with small talk and what is going on. This client</td>
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</table>
came in and was superficial for awhile. I asked her what was going on? Based on our relationship, she realized that she was avoiding talking about things that we had previously identified. We focused on what was going on right then between her and I. She said she was embarrassed to talk about it. We talked about how what had happened affected getting close in a relationship now. I have warm afghans that clients can wrap up in. don’t know if that is play therapy, but I want them to feel comfortable. I have candy in my office and a warm, inviting atmosphere.

<p>| Why did you choose to use this technique at this time? | I focus on the therapeutic relationship. Previous relationships affect present relationships and I use the therapeutic relationship as a tool for looking at the past and healing it. |
| Are there other techniques that you frequently use? | When I was in private practice, I sometimes had lower functioning clients. They weren’t always able to express themselves in words. I used art therapy, coloring, drawing, games. I inherited my parents therapy dolls. |</p>
<table>
<thead>
<tr>
<th>They are doing missionary work and so I have their therapy dolls.</th>
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<tbody>
<tr>
<td>Is there anything else that you would care to share with me about play therapy with adult survivors?</td>
</tr>
<tr>
<td>No, I don’t know if I really use play therapy or not. I mainly focus on the process of the therapeutic relationship and what is going on with the client. I guess maybe I do do some. I just didn’t think of it as play therapy.</td>
</tr>
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Comments:
Play Therapy with Adult Survivors
Interview Record

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</thead>
<tbody>
<tr>
<td>How did you come to use play therapy techniques with adult survivors?</td>
<td>Well, I taught classes for all ages from kindergarten all the way to, my oldest student was 90, and I taught, I mean she was 100, and I taught art, and some of the things that I saw in my classes, no matter what age they were negative comments; so much feedback from someone else’s opinion about what they couldn’t do. A friend of mine said, you already do art, why don’t you go to school to be an art therapist, so I did. There was an opening for an Art Therapist and so I applied and here I am. I learned about Dr. Ross’ Trauma Model and the person’s inability to express some feelings.</td>
<td></td>
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<tr>
<td>How do you determine which clients you will use play therapy techniques with?</td>
<td>Trauma patients have issues with relationships, grief and loss, anger – we do specific things to get their body involved, like movement therapy, anger work. Even though they may feel the anger</td>
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</table>
in their body, they cannot express it verbally. Art therapy is available to all the patients, but I work primarily with trauma patients.

<table>
<thead>
<tr>
<th>Would you describe a session where you used play therapy techniques?</th>
<th>I am thinking of a patient who was abused and expressed being angry at her mother. I asked her to draw her anger. I might use color. For example, I might ask you what is your favorite red food? You would say, ‘strawberries’. You have eliminated other red foods like apples. There is something very particular about strawberries. When I ask you why, you would say, “because it reminds me of walking in a field with my mom.” We would then talk about that.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why did you choose to use this technique at this time?</td>
<td>Trauma patients say, “I don’t feel my feelings.” They may not be able to say what they feel, but they can draw it.</td>
</tr>
<tr>
<td>Are there other techniques that you frequently use?</td>
<td>Any type of therapy that involves the creative side is set up with 2,050 choices. Play therapy, art</td>
</tr>
</tbody>
</table>
| **Is there anything else that you would care to share with me about play therapy with adult survivors?** | **It is a process. You can’t fix eighteen years of trauma in a month. These people are survivors. They have learned to cope. They may be poor coping tools, but they figured it out on their own.**

Trauma intensifies negative feeling from others. . to a point where it interferes with regular development.

You need a safe environment where the person can come back repeatedly. You can’t eat an elephant in one bite and you can’t undo or fix years of trauma quickly, but the play therapy helps the client to get there faster. |

Comments:
Interview Record

**Play Therapy with Adult Survivors**

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<tbody>
<tr>
<td>How did you come to use play therapy techniques with adult survivors?</td>
<td>Well, I had a client who came in and she was in her anger at the time. She said she wanted to rip my office apart. And, I thought, what could we use as an alternative? So, we went in to the playroom and made playdough balls. We made an image of the abuser and let her throw the balls at it. Boy, was that effective! A lot of it is intuitive; it just comes around. Play is something that adult survivors haven't gotten.</td>
<td></td>
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<tr>
<td>How do you determine which clients you will use play therapy techniques with?</td>
<td>Well, if you listen to a client, they will tell you what they need. It's probably what I do with all my clients. I think of it as empowerment. I teach them how to take control of their anger; how to be self-caring. I teach them how to find joy in their life.</td>
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<tr>
<td>Would you describe a session where you used play therapy techniques?</td>
<td>The client that I described earlier with the clay balls. At the end of that session, she made a clay image of herself as an Amazon woman. It was a very important metaphorical image. I've had clients who were abused at pre-verbal stages. I will have them color. You have the person re-work those early developmental stages. I had a woman with ego states at 5 and 12. I had her go out and buy Christmas presents for a child of those ages. She bought a doll. She was never allowed to play with dolls. She brought the doll in and giggled and laughed. She gave herself permission to take care of herself.</td>
</tr>
<tr>
<td>Why did you choose to use this technique at this time?</td>
<td>Because the abuse occurred at those developmental stages. In the case of the client with anger, she wanted to trash my office, so I had to help her work it out.</td>
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<td>Question</td>
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<tr>
<td>Are there other techniques that you frequently use?</td>
<td>I use hypnotherapy to get to the key memories. I use journaling big time. I assign homework for example, for someone with anger issues, I may have them break clay pots or scream in the car. I may have them color their emotions.</td>
</tr>
<tr>
<td>Is there anything else that you would care to share with me about play therapy with adult survivors?</td>
<td>I try to help clients find joy and balance in their lives. I tell people to honor their emotions, because that's what tells you what you need.</td>
</tr>
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</table>

Comments:
**Play Therapy with Adult Survivors**

**Interview Record**

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<th>2004-005</th>
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<tbody>
<tr>
<td>How did you come to use play therapy techniques with adult survivors?</td>
<td>Well, partially because of the training at Andrews; although I don’t think they had a course specifically in play therapy in adults. But, finally, I did my work at Eagle Village, where they did live interventions – they call them interventions.</td>
<td></td>
</tr>
<tr>
<td>How do you determine which clients you will use play therapy techniques with?</td>
<td>Clients don’t necessarily come for sexual abuse matters. It comes out in the process. Sometimes, talking just doesn’t work and so, using experiential types of interventions does. I just use them when a client is stuck.</td>
<td></td>
</tr>
<tr>
<td>Would you describe a session where you used play therapy techniques?</td>
<td>See the board over there? It is a table with rollers underneath them. They have to discuss the rollers as being things</td>
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<td>-------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Why did you choose to use this technique at this time?</td>
<td>I used this technique at Eagle Village and it worked, so I just continue to use it. It can be a very powerful . . . awareness.</td>
<td></td>
</tr>
<tr>
<td>Are there other techniques that you frequently use?</td>
<td>Other helpful techniques to use include using a puzzle. You dump it out on the table and say, “This is your life” and you ask them to put it back together. If you don’t have the picture to look at, it helps them to problem-solve. Ask them what their process would be? Most always they will say do the border first.</td>
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<td></td>
<td>I also use art. I have clients draw pictures of</td>
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<td>themselves and what they are feeling.</td>
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<td>---------------------------------------</td>
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<tr>
<td>Is there anything else that you would care to share with me about play therapy with adult survivors?</td>
<td></td>
<td></td>
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<tr>
<td>Just that it works.</td>
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Comments:
### Interview Record

**Interviewee:** ______2004-006________ **Date:**

**Phone:** _______________ **E-Mail:** _______________

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<tbody>
<tr>
<td><strong>How did you come to use play therapy techniques with adult survivors?</strong></td>
<td>I see clients at Forest View and have worked with Dr Ross there. He specializes in victims of sexual abuse. Dr. Ross’ and Dr. Charles Whitfield talk about the Trauma Model. They use play therapy at Forest View. Adults who have been sexual abused as children have attachment issues. The [child’s] developmental stage stopped at the time of abuse. I give them an object, a talisman, if you will, to represent where they were at the time of abuse. They keep it with them. It serves to ground them...you build on trust and go to object permanence.</td>
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<tr>
<td><strong>How do you determine which clients you will use play therapy techniques with?</strong></td>
<td>One therapy does not fill all for adults with [childhood] sexual abuse. If they are dissociating, you have to design your therapy to the level that they are at. You have to listen with</td>
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</table>
your head and heart in a person’s history.

Our assessment has to be as accurate as possible, so that we develop appropriate interventions and modalities that are age appropriate.

Would you describe a session where you used play therapy techniques?

I have two clients that I have meals with. We sit on the floor and eat. Then, I read them a story. You can’t touch them, but I have a rocking chair and they may sit in the rocking chair and I will rock the chair. I may give them a blanket to feel warm. I do not hold clients. I use transference. You go through the whole objects relation process. So, the way I touch them is that I rock them. I give them a blanket or I put a pillow against them so that they feel my warmth, but it’s not me. It’s that I am rocking the chair, but they have a blanket around them. I am sitting beside them.

Why did you choose to use this technique at this time?

Sexual abuse occurred at an early developmental stage. The client did not learn to trust and needed to learn self-nurturing.
<table>
<thead>
<tr>
<th>Are there other techniques that you frequently use?</th>
<th>Play therapy can be anything from psychodrama to art therapy to anger work with clay balls and throw them at the wall. I have used clay work. [There is] painting and finger painting, role-play, sand, videos, and stories.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there anything else that you would care to share with me about play therapy with adult survivors?</td>
<td>The work has to include the spiritual component; a balance of mind, body, spirit. Dr. Whitfield talks about we have to first do work in our head and our heart. Play therapy is about being vulnerable; it's learning how to share; how to break bread with one another. It's learning how to cry with the client. Therapists have to be doing their own work and having their own support system or they're going to get involved in an area where they are projecting their own feelings on to the client and it is going to be a disaster for everyone. I can't believe that many of the professional training centers do not make it mandatory that</td>
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<td>you have to have had X number of hours of individual and group therapy yourself.</td>
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Comments:
Play Therapy with Adult Survivors
Interview Record

Interviewee: 2004-007. Date: ______________________________
Phone: ______________________________ E-Mail: ______________________________

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<tr>
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<tbody>
<tr>
<td>How did you come to use play therapy (psychodrama)</td>
<td>[I] started with a patient in the psychiatric unit, and I was supposed to [do] psychodrama with the general adult population, and then [I] began to use it with folks who have been traumatized.</td>
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<tr>
<td>techniques with adult survivors?</td>
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<tr>
<td>How do you determine which clients you will use</td>
<td>Exclusionary criteria for psychodrama would be psychosis or a person who is dissociating. It has to be some sense of reality orientation.</td>
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<td>play therapy (psychodrama) techniques with?</td>
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<tr>
<td>Would you describe a session where you used play</td>
<td>At some point, I am always looking to follow the affect. I do believe the most troubling dynamic for patients with trauma is having to deal with unresolved affects. I'm always trying to follow affects. And at moments when a person gets closer to affect, that's certainly when I use more experiential techniques. I might introduce role playing or use of imagery, or any of the others. For some people, I have outside of session, maybe more prescribed doing some journaling or</td>
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<td>therapy (psychodrama) techniques?</td>
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<table>
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<tr>
<td>Why did you choose to use this technique at this time?</td>
<td>Because it was an affective moment when you were going with the emotion. Either that or if I use it outside of a session, is to stimulate movement in that direction.</td>
</tr>
<tr>
<td>Are there other techniques that you frequently use?</td>
<td>I use a lot of cognitive grounding sort of techniques, educational stuff. Because while the person who disassociates needs to work through feelings, they also get very easily overwhelmed with feelings, so you really do have to do a fair amount of cognitive work. Psychodrama and role playing; some imagery. Some relaxation. For anxiety, I do use cognitive behavior techniques, and a lot of it is affect or expressive work dealing with underlying grief. Journaling and anger management.</td>
</tr>
<tr>
<td>Is there anything else that you would care to share with me about play therapy with adult survivors?</td>
<td>Well, I think I’ve already made the major statement I would look beyond play therapy, particularly with adults, because you won’t find play therapy with adults. Play therapy is really an entity in and of itself, which can be</td>
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</table>
certified, etc., so true play therapists would probably not agree with your rather broad definition of it. There's another term and that's the creative arts therapy. And in fact there is an organization of creative arts therapy. What you're really looking for is drama therapy, movement therapy, psychodrama, some educational therapy, creative art therapy. I used to be the director of an activity therapy department in which all of those disciplines worked together. Activity therapy, creative arts therapy, experiential therapy; those are the terms used in the field. Like I said there is an organization, the creative arts therapy organization, that's an umbrella over all of those. Each of those disciplines has a national organization as well. So there should be literature under each of those particular disciplines. I do a fair amount of drawing with distorted body image.

Comments:
Play Therapy with Adult Survivors
Interview Record

Interviewee: 2004-008  Date: __________________________

Phone: _____________________________________  E-Mail: __________________________

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<tbody>
<tr>
<td>How did you come to use play therapy techniques with adult survivors?</td>
<td>I only had one office and it was a play room and the adults were there, and I did sand tray. It was just sort of natural. You almost couldn’t not play. I had a defense attorney and a district attorney meeting with me in my office one time and the two of them went over and starting battling it out in the sand. Superman and the villain. It was wonderful. I wish I had a tape. If you have the material in the room, it doesn’t matter how old the person is, they’re going to go to it.</td>
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<tr>
<td>How do you determine which clients you will use play therapy techniques with?</td>
<td>I starting out having two separate spaces and then for awhile I only had the one room, then it broke off into two rooms again. If you’re working with DID, it was easy. Because I could say to the client, I have some ideas that it might be easy for the kids to tell their story. Let’s go in and I’ll show you the sand tray. So we would just move them in there. People who came in for transition stuff – their mother died or</td>
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their kids went away to school – again I would just steer them to sand tray, and I would say here’s an alternative way to look at these things that you’re talking about and invite them to put it in the sand. Almost everybody said yes. Almost everybody. I had one guy who was a graphic artist who couldn’t relax and play in the sand. He needed to have a finished product every time, so we had to leave. He couldn’t do anything that was art. He was always critiquing it. But of course, he’s a very rigid guy despite his art talents. Most art types just loved it.

<table>
<thead>
<tr>
<th>Would you describe a session where you used play therapy techniques?</th>
<th>I had one client I was not doing any clay work with her, but again we were meeting in this room that were surrounding – 3 walls that were filled with miniatures. I don’t remember why we were standing, because usually the client sits on the couch and I sit in the chair. We were standing for some reason and out of the corner of my eye, I saw her bury something in the sand and I knew she was DID. So I went over by the sand tray and try to see what was there. I could see that she had taken a little girl doll and buried her head in the sand and left her feet out. I said “Gee I’m wondering who is trying to tell me something about this doll?” It turned out that it was a child’s alter that was...</th>
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trying to come up and trying to speak, and everyone else was trying to keep it down. And so one of the alter's said "I have to keep her down. I keep trying to bury her but she keeps coming back up. I said, "I am interested in meeting her like when I first met you. I'm interested in meeting her. I would like her to come up here in the play room. We can let her come out and let's get to meet her." From then on, with those two alters, we always worked in the sand. Always worked in the sand. And that client used the sand a lot. Sometimes she would use the sand just to diagram things and draw things, because there was a fluidity in the sand that really helped her tell the story.

| Why did you choose to use this technique at this time? | In this particular case, the client really went to it. In my office, it was really a typical play room. Everything was available to them. They tend to gravitate to the sand tray. They’re often relieved when I say to them, “By the way, sand tray is an adult therapy that adapts well to kids, but it was developed for adults”, and they all go “whew”. |
| Are there other techniques that you frequently use? | They gravitate by themselves. I’ve done DID and I’ve treated adults and kids with DID for 15 years now, and I use a lot of techniques. I use EMDR and a lot of techniques, but for play the thing that seems to work best for them. I’ll have |
a DID client, I will say why don’t we have each alter pick a figure that represents them and let’s put them around the tray. Then they’ll do a scene and then each alter can say “Ok, who sees this from a little different perspective”, and someone with say, “oh, it’s so and so”, and she’ll take her figure and she’ll tell the story from her perspective. But everyone is witnessing it. So it’s really a wonderful medium for them to use. And sometimes they don’t know what specific things to do, so I’ll suggest ways to approach it. I also have clients who have done collages in the past and will say, “Do you still have those pictures?” I have bins of cut up pictures of all different kinds, because cutting out pictures is what takes the most time and wastes your 50 minutes. So I cut out pictures. We used to cut out pictures during play therapy meetings. For me, I would have some pictures that were quite provocative. So I would get magazines specifically for that, like Scientific America or things like that, that would have pictures that could be interpreted different ways. It’s always fun.

Is there anything else that you would care to share with me about play therapy with adult survivors?

With that kind [of work], each alter that has a figure that fits [it]. And each client has kept those alters and told different stories, and they’ll go and get their figure. And I’ll be in the middle of doing...
some work with somebody, and she'll switch and walk over and get a figure, and I'll recognize that it's a figure that another alter always uses, and I can say, "Is that you, Amy?" And she'll say yes. And I'll say "Oh, so you were there that day too. So tell me what happened with you. And then she can tell the story. Often times, an alter will stay out during some abuse until they just can't take it anymore, and they go away and somebody else will come in the middle of it, and they'll take it as long as they can, and then they'll go away and somebody else will come out. So when you do that kind of thing in the sand, it's "Well I was here until then", and I'll say well what happened next, and it will be "Amy can", and I'll say, "Ok, Amy, can you tell me what happened next?" With everybody else's piece of the story, they get pre-consciousness about the story and they realize oh, yeah, I went away but the abuse kept on happening, and so and so came in. It gives them a chance to see that there's a bigger picture than their little slice of life. A dissociated alter only sees a little slice of life, so sand tray is a wonderful medium with dissociation. The woman I think is the best sand tray trainer is Gisela deDemina, and she's in Oakland or Berkley, one of those...
northern San Francisco suburbs. She's a wonderful sand tray teacher.

What sand tray lets you do is stand apart from whatever you're putting in the tray, and gets some distance from it, but you're still attached to it because you built it. It just allows you to look at things a little differently. I did a sand tray a couple of weeks after my mother died, and my therapist died 5 days after my mother did, and I had the sand tray workshop come up and I was lucky enough that there was an extra person in the room, so Gisela got to be the person who was working with me. So I was doing this whole thing about death and transformation and being left and that kind of stuff. So I built this tray that had a barrier between life and death. And Gisela was able to say to me, "Ok, so now I noticed when you're standing here and you're looking at this from this perspective, when I get down at this level and I look right at the perspective of the figure, this is what I see. But I wonder what would happen if you changed your view a little.? Can you see through that? Can you see this a little differently if you just shift your gaze? And it was really magical because when I got down at the level she was talking about, I could see through the barrier that had I
created to separate life and death. And I got to see a glimpse and it was a great metaphor, because I was able to say yes, I can feel that. I realize that I can still have this relationship, but it won’t be the same. It was an amazing perspective. Just a little shift. Little tiny thing that you can do. And I don’t know if I could have gotten there in one hour. It’s hard to describe this shift that I was able to do.

There’s a drawing technique that I’ve used with kids and adults, where you take a stack of paper and you staple it across the top so it becomes a tablet. And you tell them to draw themselves as they are now, and then you lift the page and say now draw yourself as you were before such and such happened. And then you pick it up and say, now draw a picture before such and such happened. And it’s interesting to see how they represent the changes – the changes that life or death has created for them. And kids love that exercise.

I’m really glad that you’re going to publish something about using play with adults.

Comments:
Play Therapy with Adult Survivors
Interview Record

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<tr>
<td>How did you come to use play therapy techniques with adult survivors?</td>
<td>I have an art therapy background, so when I started understanding play therapy, all the things I would use art for, it made sense to think about play therapy. Some of them wanted to play, especially DID survivors, not necessarily because they had young parts, but maybe because they had embraced their young parts they weren’t inhibited about that. But that would be one reason. I think the sand play obviously is used for everybody, and I had shared an office with a sand play therapist, so I was familiar with the sand tray. I learned a fair amount of that. Kids watching things they could do, applying it to adults, symbolic communications that I would use with art. I would take a technique that I would use with art and then use it with play. For instance, draw something that would represent every member of your family including yourself. Pick a container with something in it to represent each person. I have all the animals in my office, so chose an animal to represent each person, and then use a psycho traumatic type technique to communicate things using the animals that the family</td>
<td></td>
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<tr>
<td>How do you determine which clients you will use play therapy techniques with?</td>
<td>Sometimes they express an interest in play or art, or if I feel that there is dissociation and a lot of memory blockage, I would use the sand tray because I find that it allows expression of dissociated parts or dissociated trauma. If something really needs to be profoundly grasped, I like to use imagery or play to get more deeply dealt with in the unconscious. I think that art and sand play get deeply remembered more over time. A dissociated child that wants to show me something that happened to them, sometimes they are afraid to put it into words, that would be a good time.</td>
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<td>Would you describe a session where you used play therapy techniques?</td>
<td>I have a technique that I like to use a lot. I use it in a lot of varied ways. Choose an animal to represent how you felt in relationship with somebody, and then choose an animal to represent the mother while this was going on. And then choose a spiritual figure within the room. I might choose a doll to be me to come in and be able to speak with the animals, so my doll talks to the animals, but it might start with their animal for instance a turtle, saying to the other animals, you made me feel like a turtle, etc. You were like a lion because. . . . And if they’re having trouble, I would have the spiritual figure help them express their feelings, and then the spiritual figure helps them to clear the truth about what was happening here and who was responsible for it. Then might have them refuse to be the turtle.</td>
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if there was a negative thing about it, or they might want to stay a turtle because of the shell. And they can take another animal to be how they fit the parents now, now that they’ve gotten past some of the stuff. Now they see through to the parent; pick an animal that represents what was going on inside the parent. I would have someone pick a wildcat cub for instance to be what was really driving the parents which was the parent’s own abuse and fear and need to feel security, etc. Using imagery to deepen an understanding and to move past badly foreseen adults. Sometimes I’ll do a prayer of renunciation. For instance, I declare the power of the gentle shepherd; I renounce the way that you made me feel about myself, that I was inadequate, that I was nothing, etc. The truth is you made me feel this way because . . . and I declare this null and void and forever broken, and in its place I ask God to bless me with a deep knowledge that I was good, kind, and that I am strong . .

| Why did you choose to use this technique at this time? | Anger management. . . What’s constructive and what’s destructive anger that I impose on people. I do some role play. I definitely try to move people into expressing their anger with words because I think that can reduce the likelihood of acting it out especially if you can express your anger with words about what you’re truly angry about. |
| Are there other techniques that you frequently use? |  |

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So it's kind of like anger having to do with displacement; anger towards something deep. Reducing displacement and generalization. I think that when someone has been abused in a terrifying way by somebody, they tend to generalize their anger because they're too afraid to become conscious of being angry at someone their so terrified of, or the experience of what happened by that person to be completely dissociated because of the terror, so they need to be conscious of who to get angry at and direct the anger toward that person and put it into words. I think it not only going to help a person not act out physically, but be much more to the point as far as letting them express what they are angry about so I use that in psycho-traumatic type techniques. I'll take a dummy quite often and put it in a chair and do that. Then let me say what they feel. Then humor may come in. If I have a person who is physically out of control, I would not let them beat it up. I definitely want them to express their anger through words.

Is there anything else that you would care to share with me about play therapy with adult survivors?

I try to be sort of limitless in my way of thinking; unstructured, non-directive. To me it's limitless play in art. I use a model. I very much believe in the unconscious mind. No matter how out of fashion that's become or how cognate behavioral the whole world is becoming, screw them. They can go on their own little task and leave me alone. I definitely believe that change happens from deep inside. That

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technique I gave with the prayer, to me that’s taking a cognate behavioral type idea that has to do with a concept of abuse based belief, but that I believe to change that should be done in an in-depth way, how to make it deep with play art or prayer, or both. If you just talk about it on the top, you’re not going to get into the unconscious. If you’re dealing with imagery through art, or if you bring in something spiritual, you’re going to make a change both cognitive and emotional that’s going to have root. To me a cognitive would be like clipping the leaves on top of an infected tree, that’s cognitive behavior to me. If you put some plant food and something that handles the infection into the earth, that’s more how I see it and I think you get to the earth with play and art and spirituality. I’m trying to affect the unconscious. I’m trying to reach the unconscious and have them express the unconscious with the play. It always happens. Whatever they pick, even just picking animals, the symbol of the animal is multidimensional and hold more information that a sentence will. Just use it as much as you can. Use the play and the art as much as you can. That will always get deeper and more memorable and have a more profound lasting effect. It will be something they will remember when they come to see you 10 years later.

Comments:
Play Therapy with Adult Survivors
Interview Record

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<tr>
<td>How did you come to use play therapy techniques with adult survivors?</td>
<td>I began using play therapy when I was working with children. Once I started using it with adults, I started taking some workshops with Suzanne Long. Some of the workshops covered doing work with adults, particularly the sand. I did find that for adults who have difficulty accessing their feelings, it seems to work pretty well. I actually use it more with children and teenagers because most of the adults are pretty verbal and they’re there because they do want to talk about it.</td>
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<td>How do you determine which clients you will use play therapy techniques with?</td>
<td>They are usually the clients that tend to intellectualize, and I feel resistance, or they’re quieter and when I get to the point where I’m doing all the work.</td>
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<tr>
<td>Would you describe a session where you used play therapy techniques?</td>
<td>I invite the adult to use the sand tray, and I explain what the process is. I have small room separate from my therapy. Then I allow the client to first experience the sand with her hands. Then I ask her to create her landscape in the sand and then bring her to the shelves where I keep the sand tray miniatures and ask</td>
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<tr>
<td>Why did you choose to use this technique at this time?</td>
<td>I use other techniques, but the sand tray is more of something that adults can access and relate to, and it allows for the use of symbolism, and to explore the meaning of symbols.</td>
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<tr>
<td>Are there other techniques that you frequently use?</td>
<td>I had been working with children in an agency setting, but I had some adults that I would see in the evening in my private practice. So it was probably during that time. The children actually don’t do as much on the symbolic level as the adults. Children, particularly the younger ones, tend to be more concrete. They’ll play in the sand more than they’ll set things up symbolically and then talk about it.</td>
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<tr>
<td>Is there anything else that you would care to share with me about play therapy with adult survivors?</td>
<td>I think that in many, many cases, the adults have learned ways of adaptation and coping skills. Some of which are not particularly healthy, and that’s usually the thing that brings</td>
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them in. And we’ll address those coping skills. And then that would requires working the here and now, but then build insight and help them understand where these things came from and why. We’ll go back in the childhood and talk about issues. I actually have a number of clients that will come in and it’s not immediately apparent for quite some time that there’s sexual abuse in their background, and yet in talking about their interpersonal struggles, eating disorders, substance abuse, relationship problems, problems with their children, sometimes it will just kind of pop out and as always there’s “ah ha”. I guess I feel that it’s more of a confirmation. I guess I’m trying to say that the client is not necessarily focusing on that or speaking about that. They’ve put it way in the past and buried it away and not seeing the connection. And then once he makes the connection, very often it becomes a lot more clear, the work that we’re doing, where to go with this. So it’s very often the key from the past that unlocks the present.

| Comments: MR: Well, you’ve just confirmed what I have suspected that a lot of clients do present with other problems, and because they are survivors, they have developed those coping skills somewhat not too effective, and so they come to therapy for something else when, in fact, behind that, there’s this abuse. That’s what I’ve been going on is that using the play therapy or experiential techniques brings that person back to that time to heal. You have confirmed what I have believed.  

There’s really only one client I can think of who is an exception to that, and she had come in specially to work on her childhood sexual abuse. She was fairly high |

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functioning professionally; been married once and divorced maybe a year before she came in to see me. The marriage didn’t last more than 3 years. She was in her mid-40’s, it revealed that when she was a teenager in her early-20’s she had been institutionalized and was very suicidal and had major eating disorders, specifically anorexia, very bad family relationships, and accused her father of having sexually molested her. The family turned against her, everyone in the family became very, very angry. And the family denied it and said that never happened and she was making it up. And that kind of how it remains to this day. She does have some contact with them. She said she wanted to go back and revisit the sexual abuse, but when I tried to get her back there, she said she couldn’t remember anything specifically. She said she remembers waking up and feeling this dark presence, and remembers being entered annually and the pain, but she couldn’t see or hear anything. There was nothing she could tell me what age. No specifics. So it was never really clear to me that these were actual memories or maybe dreams, or what. I tried using play therapy with her, she was pretty resistant to that. She would get very hostile and angry with me when I would try to work with her in terms of the impact that this had had on her relationship; her feelings of loneliness and wanting to connect with people, but not wanting to work on those issues. We finally ended up where I referred her to a colleague of my because I got to the point where I found that I was disliking her intensely. And I think she’s very borderline with the sexual abuse. I felt that we were really at a no win situation. She couldn’t really process what she couldn’t remember, and yet she kept insisting she wanted to process it and move on, but she didn’t want to let go of it either so that she could move into the present. That was kind of a tricky situation. I think that was the one negative experience that I had.

MR: Yet it sounded like you may have taken her to the next step where she needed to go, and so your time with her was probably more worthwhile than you may know.
Play Therapy with Adult Survivors  
Interview Record

Interviewee: 2004-011  
Date:  
Phone: E-Mail:  

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<td>How did you come to use play therapy techniques with adult survivors?</td>
<td>Just seemed natural. I think probably the best way of describing it is talk therapy allows people to stay in their head, where expressive therapy when you’re using more than one sense and one way in which to discuss and process what’s happened. I think it’s more affective. I think the biological and chemistry of trauma lends itself to that. It’s a more holistic approach and I think it enables people to be able to deal with their thoughts as well as their experiences.</td>
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<td>How do you determine which clients you will use play therapy techniques with?</td>
<td>I think probably the only thing that I would say to that it depends upon the client. I have a gentleman that I’m working with that was sexually molested in a cult. It’s pretty obvious he needs to also be able to have access to a healing so that fuller processing will happen. So we just started and I said put it in the tray. So he figures it out and put it in the tray and I saw how</td>
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he handled it. And he did fine with it. He said “Wow, I’m feeling more than I’ve ever felt before”. And so then we go with that a little bit. I would not make someone. I would offer it and if they said no, I’d say okay. And then I’d sit with them until they were able to tolerate it. With sexually abused people, especially when they’ve been abused as a child, maybe a little more so. I think they need to learn how to tolerate their feelings, so I do a lot of expressing of feelings. And so I might tap up to either the experience or tap up to the feelings associated with it, and then we’ll back down so that helps to build that tolerance level. So that’s how I do the play therapy techniques, the expressive techniques. I think you have to be a little careful because people often don’t have the tolerance, and you don’t want to just throw them into something and then they flood. You got to build the experience a little bit and their ability to tolerate what happened to them.

<p>| Would you describe a session where you used play therapy techniques? | I had one gal who was a molest victim that was feeling a sense of shame about sexual relations with her husband, and I had her draw the shame. We just moved from the sofa to the table and she put it in there. Another guy had some |</p>
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<th>molestation experience had put up a wall. I asked him to go to the sand tray collection and pick the wall and put it in the tray. So then he took the wall home for the next six months. He took a piece of the collection home and kept it with him. And processed the trauma and six months later he’s engaged.</th>
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<td>Why did you choose to use this technique at this time?</td>
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also, if you can deepen the experience in them in the modality that you’re using, you more fully experience it too. It can be at a distance, but it can also be something that you’re fully experiencing, and the tray is one of the ways of being able to do that.

Are there other techniques that you frequently use?

I also use EMDR in combination with play therapy, and that’s been highly effective. The gentleman I was telling you about with the cult experience, we put the figures in the tray. And when he put the figures in the tray, he put the reasons why he was susceptible to cult experience, why he got sucked in, that was his big question. He also put in that tray a lot of resources. So then we started the EMDR by installing the resources in a sense of him being able to have survived. So that’s the first phase of the EMDR before I go into some of the pretty horrific experiences that he’s had. I don’t just go in and do the EMDR. I think that’s a real problem with people who do EMDR. There is tremendous trauma. I go in a little slower and I think the sand tray and some of the expressive works gives me a way in which to find a path.

I had another one with rape at a early age, and with this gal we did a sand tray and
some of the feelings about her rape came up. Then from that, that deepened the experience because she was very dissociated from her experience. So then we took that and started utilizing it with the EMDR.

I have other ways that aren’t sexually abuse cases. I have a little boy that was traumatized by a 2nd grade teacher because she was getting ready for the standardized testing, and in California we gave bonuses to the teachers. So she made the children take test after test after test until they got it right. The little boy is learning disabled, so that was a bit of a trauma. So I had him draw it, then I had him put it in the tray. When he was drawing it, I was doing the EMDR with him. Then he moved to the sand tray, put it in the tray, and we did psychodrama about it. That’s utilizing all the different modalities within one session. It was highly effective. He’s getting ready to take the standardized testing when he’s not anxious, and not acting out, and he sort of made sense out of it. And I did that purposely because he was in second grade when that experience happened to him, and the figure that he picked was a person surrendering, and the figure that he picked this time for
how he feels towards the teacher whose making him take the test, he’s got a gun and he’s getting ready to shoot her. A real difference between surrendering and getting a gun and being able to protect yourself and stand up for yourself. And that came from the drawing with the EMDR, and that moved into the sand tray, which moved into the psychodrama. There was a physiological component to that too. You’re utilizing all of your senses. That’s a recent experience that could have been in some way applied to another client. I sort of go with what happens in the room at the moment and the particular situation of the client and how they’re responding.

Is there anything else that you would care to share with me about play therapy with adult survivors?

It’s honoring work. I feel very honored that people are willing to share that with me, and I think therapists honor that. I think you have to really understand the difficulties that people experience in their abusive situations, and not try to push someone into doing something until they’re ready. Sometimes people get inpatient. Traumatized clients don’t often get better in the number of sessions that the insurance company thinks is appropriate. And even though I use the EMDR, which is considered a brief therapy, I don’t think I use
it in that way. I use it in combination and I go very slow because I think people need to be the ones to determine where they go and when they go. I think we sometimes have a believe that they have to be a certain way. I have a gal that was abused sexually and physically and has dissociative identity disorder. Only one, that’s all I can handle. Some clinicians would say the goal is integration. And I’m not going to say that. The goal for me is for my client to be stable and for her to feel comfortable in what her response is. And I don’t have a right to say what she can or can not do. As one of her alters says, “You want to murder me?” No! You guys get to decide who gets to do what when, and whether or not it still works. Who am I to say this is what we’re going to do. I don’t do that. I tend to work with folks in that way. The guy that was in the cult, we’re developing a treatment plan together, he and I. I’m not developing a treatment plan for him. Because he needs to decide what he wants to do, and he’s frankly a little ambivalent. “You want me to what? Go back there?” Why would I want to do that. Well, it’s true I do run hot or cold. Yeah, it’s true it’s 110% with my wife, but
sometimes I'm not there and she complains about that. He gets to make the decisions about what he gets and wants to do. And that's honoring them.

Comments:
**Play Therapy With Adult Survivors**  
Interview Record

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<tr>
<td>How did you come to use play therapy techniques with adult survivors?</td>
<td>Because I mostly work with kids/ families, I have always done most of my therapy in the playroom. Earlier in my career, I only had a playroom so it served as “office” as well. I was working with an adult survivor (who had previously done Filial Therapy with her son with me) in my playroom – doing mostly “talk therapies”, cognitive behavior tx, and some art therapy. During a rather intense session, she regressed and dissociated a bit. So being at a loss as to what to do (quite early in my career), I began using toys to help her feel safe and to help with her feelings. It worked well, and I began using more play with this pop’n.</td>
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<td>How do you determine which clients you will use play therapy techniques with?</td>
<td>Because I see play and humor as essential and powerful coping/adapting mechanisms, I now find ways to use them with all clients, unless it simply does not fit their problem. The key issues for using play therapy with adults are: (a) the nature of my relationship with them, and (b) the timing. There must be decent rapport and trust before I do much play therapy, although I use humor from the start. Play therapy can be powerful, so the timing must be considered so the client’s own defenses aren’t circumvented, and the client feels ready to handle the</td>
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<td>Would you describe a session where you used play therapy techniques?</td>
<td>I have used both non-directive and directive play therapy techniques with adult survivors. Sand tray and identity activities have been very useful. Here’s one directive intervention I’ve used. One woman had been working hard to remember some details of horrific childhood sexual and physical abuse. Remembering was a long process because of many defenses, including hidden assumptions that she was worthless, deserved it, etc. I used the “Disaster Dinosaurs” intervention with her (one I created in 101 More Favorite Patient Techniques Book), giving her a bendable dinosaur and asking her to put a cast on it because it was hurt. Working entirely in metaphor, I then had her tell the dino’s “story”. She had applied casting material to most of the dino, and after telling the dino’s story, she tearfully commented that she was like the dino – innocent but hurt in many ways. Afterward, we discussed her need for, and her right to, self-care (tying the dino metaphor in with her own life).</td>
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<td>Why did you choose this technique at this time?</td>
<td>We had been talking for quite some time and results were slow. Her self-blaming was preventing progress, and I wanted to help her see that the pain and myriad feelings she experienced were “normal”, given the circumstances. I also wanted to move to more right-brain activities to help her</td>
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access some more of her childhood experience. I began using play therapy interventions every session, intermixed with our discussions. I used this one early on to help her understand her right to heal, and because it's relatively non-threatening.
### Play Therapy with Adult Survivors

#### Interview Record

**Interviewee:** __________

**Date:**

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<tr>
<td>How did you come to use play therapy techniques with adult survivors?</td>
<td>Mainly because I’m a registered art therapist. That’s the most effective form of therapy with adult survivors.</td>
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<td>How do you determine which clients you will use play therapy techniques with?</td>
<td>I use art therapy with all of them. And with patients who have DID, then it’s very easy to use more play therapy: sand tray, puppets, things of that manner. The art therapy with DID is very effective because it helps to clue all the different parts of the system into each other; it’s the knowing part. With play therapy, it just validates each of the egos and alters, especially the children. Mainly the children and there’s often the latter part that emerge and they don’t need much. Just something. And it’s safer for them. They don’t talk; they have lots of secrets. In art therapy, they can show you things that are secretive that don’t feel as threatening to show you. It’s actually much richer through art. Some of the very little ones can’t draw.</td>
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<td>Why did you choose to use this technique at this time?</td>
<td>Briefly, it depends on what’s presenting and where the adult client wants to go. Sometimes we look at art work that’s already been drawn. Sometimes I intervene and do some directive stuff. Sometimes I say, “What do you feel like doing today?”, and then it’s</td>
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more spontaneous. That’s where the client ego is based. I have a few DID clients that trigger in my play room, and all I have to do is say, “Look, I would really like to go back into the play room.” And then they trigger into their system where they’re children. That changes because it’s a transitioning process and I want to stay there with them. That’s a good sign when they don’t want to go there any more and are aware. I may suggest if they would go to the play room and very readily say yes. And usually it is yes. Because at that point there’s some caretaker that knows they are there to nurture the children. Adult survivors that don’t have DID, I don’t often suggest the play room. It would be something that might happen spontaneous in therapy, like some will play or doing some inner child work, but it all depends on where they are in the session, because it’s very different.

Are there other techniques that you frequently use? A typical session with an adult is that we start back in my intake room, and I ask them if they’re having therapy, and if they’ve brought any art work and would they like to share it. And usually these are folks that have been primed and know that this is what we do. So then we’ll share art work. I have another room that’s more like a studio room and then I’ll suggest that this might lend itself to further exploration. And then we usually close in
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<tr>
<td>Is there anything else that you would care to share with me about play therapy with adult survivors?</td>
<td>I've witnessed so many tears in adult survivor drawings. I've seen so many new beginnings happen in drawings where the transformation occurs. Usually the art therapy will parallel the progress that's being done in all the therapy. It is a gateway, but usually also parallels the work in any art or play therapy that I do. It's still to me very important because it's what I do, but I work along with treatment teams, psychiatrists and nurses, so it is on the junctive part of the process. It's not the whole process. They're not going to be filled totally by an art or play therapy intervention, but it is part of it. It brings a lot of safety and a lot of new information to the survivor. They become very empowered and enriched by the new information. Art therapy, when I have adults that are artists, the spontaneous art works beautifully. But when I have people that are not artists, I have to be more concrete and a little more directed. That's much more helpful to them. It gives them a frame work for creativity for their mind. And they need that; they need a theme. Draw me a safe place in the storm. They</td>
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need me to say, "Draw me the guilt trap". They need that framework.

Comments:
Play Therapy with Adult Survivors
Interview Record

Interviewee: ________ Date: __________
Phone: ______________________________ E-mail: ______________________________

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<td>How did you come to use play therapy techniques with adult survivors?</td>
<td>The sand tray is in my office, so they’ve been curious about that. So when they get stuck, it’s not about the actual abuse, but it’s more about some form of powerlessness. Let’s put it in the sand; what would that look like so I can get a clear picture. So often they’re a little hesitant, but sometimes they do it. I just say to them that you can create your story or the problem and you can use the figures, as many or as little as you want. You decide.</td>
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<tr>
<td>How do you determine which clients you will use play therapy techniques with?</td>
<td>When the client is stuck and feels powerless, then let’s put it in the sand. They do a lot of EMDR work so sometimes that imagery is my main piece if the EMDR works.</td>
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<td>Why did you choose to use this technique at this time?</td>
<td>Primarily, it’s when they are stuck. I have not had it where that’s been the core of their therapy. I don’t know why. We don’t go there first.</td>
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<td>Are there other techniques that you frequently use?</td>
<td>We usually use the talk therapy technique. And then it has been a great reference to refer back to, or re-invite them to do another tray about the next piece or their process. With adults right now, it’s more on the newer end. They can then refer back to that emotion or incident much more readily or clearer. It’s seems to</td>
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have a better grounding for them. I’m really careful with art therapy. I have one right now that would really like to try it. So I don’t know where that will go. That’s her background - art. Another one is way too powerful. She can’t do it. And another one it just dabbling at some early images. I don’t have them do it here cause the don’t want to do it here. They want to take that home. Kind of like a homework assignment, and then they bring it back.

Is there anything else that you would care to share with me about play therapy with adult survivors?

With children, it’s just distances. It’s so much easier to talk about what’s in the sand tray with adults. It’s the same with children. It’s so much easier to talk about the figure than about themselves. If adults can get past the silliness of it, they can usually process a little bit without the fear of that emotion. So they can stand back and look in, so to speak. It’s so easy and go there and move pieces and characters around. I would love to know about working with this because I’m more hesitant because I don’t know, and I want to make sure they’re in the right place and they’re leading.
Play Therapy With Adult Survivors  
Interview Record

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<tr>
<td>How did you come to use play therapy techniques with adult survivors?</td>
<td>My own gifts make it easy to incorporate fantasy and imagery exercises. Clients have responded well. At times, the non-rational opens a lot of other doors for clients.</td>
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<td>How do you determine which clients you will use play therapy techniques with?</td>
<td>I just suggest they try this exercise or humor me. Rarely, if ever, did anyone refuse. I do not use this with anyone who has a history of LSD use, etc.</td>
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<tr>
<td>Would you describe a session where you used play therapy techniques?</td>
<td>Used the fantasy exercise of The Rose Garden (Gil) and then discuss. Used sand box and have them do a scene/picture of how they feel (present), or just have them do one non-directive.</td>
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<tr>
<td>Why did you choose this technique at this time?</td>
<td>The Rose Garden is simple and non-threatening.</td>
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<tr>
<td>Are there other techniques that you frequently use?</td>
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<tr>
<td>Is there anything else that you would care to share with me about play therapy with adult survivors?</td>
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Comments:
Play Therapy With Adult Survivors
Interview Record

Interviewee: 2004-016		Date: July 15, 2004
Phone: ________________				E-mail: ________________

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<tr>
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<tr>
<td><strong>How did you come to use play therapy techniques with adult survivors?</strong></td>
<td>Well, I had people in therapy that weren’t making progress. Started with art therapy. Then I used kitchen items, sand tray, and silly putty. A lot of people need help going back to that time of abuse. I have things in my office: silly putty and puzzles. I have a play room and if they are stuck, I’ll take them into the play room.</td>
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<tr>
<td><strong>How do you determine which clients you will use play therapy techniques with?</strong></td>
<td>Their readiness and desire. It’s just a feeling.</td>
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<tr>
<td><strong>Would you describe a session where you used play therapy techniques?</strong></td>
<td>I had a female in her 20’s. She had been through traditional therapy. She was in a master’s program to be a counselor. I took her into the play room and said, “Let’s look at doing therapy in here.” She immediately began playing with the easel.</td>
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<td><strong>Why did you choose this technique at this time?</strong></td>
<td>I used a developmental perspective (Erikson). If you don’t have trust, you can’t deal with autonomy. I do an abuse assessment: What age the person was abused; Where are they stuck? I use trust building exercises. I have things available, i.e.,</td>
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puzzles, games, crayons, etc., so they can get back to where they are stuck. We go into the play room. Sand helps express emotions.

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<tr>
<th>Are there other techniques that you frequently use?</th>
<th>Sand, finger paint, regular paint, coloring, play doh, tea parties, games (i.e., jacks, marbles), colors – red = what makes you angry? Sit on the floor – talk to child.</th>
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</thead>
<tbody>
<tr>
<td>Is there anything else that you would care to share with me about play therapy with adult survivors?</td>
<td>There are times to be reflective (Rogers). That's when they are in the child role. I use non-directive play then. I use directive play to get in touch with emotions.</td>
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Comments:
**Play Therapy With Adult Survivors**

**Interview Record**

**Interviewee:** 2004-017  
**Date:** ________________

**Phone:** __________________  
**E-mail:** __________________

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<tr>
<td>How did you come to use play therapy techniques with adult survivors?</td>
<td>Had a lot of adults who had DID; a lot of full DID – child alters. React, stories, giving tree</td>
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<tr>
<td>How do you determine which clients you will use play therapy techniques with?</td>
<td>Having trouble expressing themselves, even some adults without DD. Stories; depending</td>
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<tr>
<td>Would you describe a session where you used play therapy techniques?</td>
<td>Female talking about responsibility; who is responsible? The other one always had to take care of child alter. Late teens – 18-19 years; not very verbal; make drawings in the sand. I used art - tree.</td>
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<tr>
<td>Why did you choose this technique at this time?</td>
<td>They helped the client to express emotions.</td>
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<tr>
<td>Are there other techniques that you frequently use?</td>
<td>Art, sand tray, therapeutic games, puppets. There’s probably others.</td>
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<tr>
<td>Is there anything else that you would care to share with me about play therapy with adult survivors?</td>
<td>It is imperative. It is a useful approach. It may help with development stages that can be met. It allows them to be more expressive.</td>
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**Comments:**
**Play Therapy With Adult Survivors**

**Interview Record**

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<tr>
<td>How did you come to use play therapy techniques with adult survivors?</td>
<td>I just really love play therapy. I went to a sexual abuse conference in Madison Wisconsin and saw John ______. He was talking about how play therapy in kids, when they do post traumatic play therapy, that is sort of like flashbacks for grown ups. They are more effective because you can get in there and see it and a better way to reprocess the things that are going on. So I said why don’t we take the flashbacks out of the grown ups heads and have them do play therapy. So I decided that that would be a good way to have them show me with toys or art what a flashback looks like.</td>
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<tr>
<td>How do you determine which clients you will use play therapy techniques with?</td>
<td>It depends on my relationship with them, and how much of the usefulness is still present. Some grown ups you feel like their a little too rigid or they “poo poo” it and they think it’s silly, but for grown ups that I have a good relationship with are the ones that have responded to play therapy.</td>
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<tr>
<td>Would you describe a session where you used play</td>
<td>I was working with a lady that was severely abused</td>
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therapy techniques?  | and she was having flashbacks where eyes were looking at her. We mostly did drawings. I had her draw the eyes and talk to the eyes. Then we had a punching bag and she punched on that a bit. It wasn’t like non-directive, it was like I’m telling her to use the art and the toys that are available to act out some of those feelings on the flashback images she was having. I’m more directive with grown ups than with kids.

| Why did you choose this technique at this time? | I really believe in play therapy. I’ve seen amazing things that kids do and the projection and they can’t help it. And the grown ups can’t help it either. When you have grown ups play, it’s a much more pure form of free association. Grown ups will do things with the toys too that they don’t recognize that they are actually doing something therapeutic. It’s more like dream work, where you’re getting more of the unconscious material than you would get just doing the talk therapy, and you can get to the inner child.

| Are there other techniques that you frequently use? | No. Just the techniques that I mentioned.

| Is there anything else that you would care to share with me about play therapy with adult survivors? | No. That about covers it. |
**Play Therapy With Adult Survivors**  
Interview Record

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<tr>
<td>How did you come to use play therapy techniques with adult survivors?</td>
<td>If I know that there is a parent that has been a victim, I try to talk about the play that I do with the child, and do some coaching with the parents to also engage in that play. It’s usually linked to the child in helping the child and vicariously that the parents are getting healing out of that.</td>
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<tr>
<td>How do you determine which clients you will use play therapy techniques with?</td>
<td>I would be looking for the early childhood trauma indicators, especially trauma that occurs from the age of birth to 3 or 4. Kids at that age do not have the type of brain development to put that kind of trauma into words, so it’s an experiential kind of trauma and talk therapy is not going to get there. I’d be doing more experiential kinds of things. I do a pretty extensive developmental history. I do it with kids, but I try to do something similar with parents or adults and what was growing up like for you.</td>
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<td>Would you describe a session where you used play therapy techniques?</td>
<td>I have used coloring and sand. Sand is really a powerful, powerful medium. I have had a client, a female sex offender, with probably one of the most tragic and traumatic histories that I have ever encountered. Coloring and dolls were pretty impactful for her. I talk with</td>
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them a lot about the inner child inside of them and see if we can’t tap into that, and what didn’t that child get and kind of a re-parenting role. Play doh was a really effective venue for one man. We talk about what was the one thing that they wanted, and one man wanted someone to read to him. I tape recorded reading a story. My in mode is usually getting them to connect with that wounded child that’s still inside.

| Why did you choose this technique at this time? | Children help me to work better with the offenders. I’ve learned from both. |
| Are there other techniques that you frequently use? | It’s so individualized. Kids come in and play with lots and lots of different toys, but over the time that they’re in therapy, they really pick a few that become their metaphor for healing. I had a little boy and he was slinky man every time he came in. He would put slinky on his arm. So I never know what’s going to work and what’s the metaphor. That’s where part of my history comes in with them. What was important; what did you wish you had that you didn’t? And for some, it was that box of 64 colors. If I can’t get anything, then I will try and get them in the sand because usually sand will open up a lot. It’s kind of dependent upon what they tell me and what their preference is. I’m a very non-directive therapist. I’m following their lead and picking up on their metaphors. |
| Is there anything else that | I’d be really interested in the |
you would care to share results.

with me about play therapy with adult survivors?

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<tr>
<td>How did you come to use play therapy techniques with adult survivors?</td>
<td>Because I am a play therapist and that’s what I do. It’s simply part of the repertoire that I offer to people, and adult survivors are so often choked in non-verbal places that play invites expression that goes far beyond words. Also, it’s with probably an expectation from the clients because I am a child therapist, and the people that have been referred to me are referred specifically by adult therapists who have been working with these folks in very traditional ways, and these people have been stuck. And so they send them to me. So the person walks in knowing that they are going to be offered or invited to do things other than sit and talk.</td>
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<tr>
<td>How do you determine which clients you will use play therapy techniques with?</td>
<td>It’s an invitation to every person who walks into my room. It’s simply here. People are invited to the sand; invited to draw. Almost all of my clients have used sand at some point in time.</td>
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<td>Would you describe a session where you used play therapy techniques?</td>
<td>I put a puzzle in front of a women. It’s a blank puzzle with 12 pieces on it. And I asked her to create on that puzzle, express any way that she was happy. Create a scene; use words or colors</td>
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however she wanted to do to fill that puzzle with her own sense of safety and happiness. The only rule was that she had to be on the paper somewhere. She could be a dot; she could look like a person, whatever. She just had to be represented somewhere. And after she did that, we talked about what that was for her. And then we very carefully took the puzzle apart, and talked about how grief and trauma come into your life your world falls apart. It’s a wonderful metaphor we use for the child that works just as well with adults. And then I gave her as much time as she needed to put the puzzle back together. During which time, she just wept the whole time. The thing that was extraordinary about this puzzle activity, all the colors she used were very muted, very pale. You could barely see what she had drawn on the page. It was all yellows and very muted shades which was an indication of her depth of trauma and her inability to be present. The degree of her inability to feel faith, even at this age. It took her almost 20 minutes to put this puzzle back together. She was so stunted and so regressed in her trauma. And all of these things spoke to that.

| Why did you choose this technique at this time? | I knew I was only going to get to see this women 3 times, so I had a plan for her. The first time I did a draw person |
and a sand tray. And I invited her to put her world in this sand. She did an extraordinary sand tray and proceeded to compensate and process. It took her back so far, so I knew exactly what I was dealing with. The second time, we did some clay activities which was also regressive but soothing and those were far more guided. In the third session, because I had no doubt what I was dealing with, I chose the puzzle specifically because the puzzle is about getting it back together and we spoke to that. That the reason we did this activity was to help remind her that as difficult her life had been, she has the capacity to put it back together and find happiness again that was once on the page. It will have lines through it; it has memories through it. But one can claim happiness again. I was doing that in a very cognitive, directive way because I was not going to see this women again, and I was not going to send her out into the world without making sure she knew she could be put back together. And it worked!!

<p>| Are there other techniques that you frequently use? | Pretty much the art techniques. I occasionally pull out the jenga game just as kind of a conversation piece when people are stuck and don’t feel like just sitting there talking. It’s about building and reconstructing and building and |</p>
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<tr>
<td>Is there anything else that you would care to share with me about play therapy with adult survivors?</td>
<td>There is another form of play therapy which I have seen used once in clinical practice which is amazing. Are you familiar with play back theater? It’s an improvisational theater technique in which actors literally act out your story. It is not psychodrama, in that you as a protagonist are not in it. You get to watch the story enacted. You tell the story and they act it out. They don’t interpret it, they don’t change it. They simply act out exactly what you said. It’s quick and it’s right there. And I have seen that done in a therapist’s office with a survivor who just could not say the words out loud of what had happened to her as a child. And so this person wrote the story as though it happened to a little girl, and then it was acted out by 2 actors. She sat with the therapist and the 2 actors and the actors would act out the scene and then they would just sit quietly and talk. And then she would read the next chapter of the story and she just read it as a story that had been written about a little girl. It brought a truth into the room in a projected 3 dimensional way that was stunning. It was an amazing break-</td>
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<td>through. Because it was from there that it could then go from it didn't happen to the little girl, it was my story. It happened to me. Oh my God, this is real. She first got to see it out there in a safe, projected way. She didn't have to own it right off the bat. It was a very tender way of helping her to come to a place of owning her truth.</td>
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<tr>
<td>How did you come to use play therapy techniques with adult survivors?</td>
<td>I’m a music therapist, so I use music as the modality for assisting clients and patients in getting in touch with their feelings. Quite often that will mean some childhood light, memory refresher, or games, or music, or toys. I will use those types of tools depending on the group or depending on the individual and the type of information that I receive from the initial assessment.</td>
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<tr>
<td>How do you determine which clients you will use play therapy techniques with?</td>
<td>Often times they will have post-traumatic stress disorders or multiple personalities. People that have been abused are depressed and don’t know who they are.</td>
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<td>Would you describe a session where you used play therapy techniques?</td>
<td>Often times speaking has become intimidating and when they are in a situation where I become their teacher, their authority, and right away they feel they are nothing; they have no self value. If we choose music, I want to explore a certain mood or emotions. Maybe I’ll ask that person what their favorite artist is and I’ll listen to that music and choose some songs that have to do with an emotion they can explore. Then it becomes very non-threatening.</td>
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<tr>
<td>Why did you choose this technique at this time?</td>
<td>I’m thinking about a person that had multiple personalities and was in music therapy and part of her treatment, and she would listen to different music and have a certain personality and then she would begin asking the other person. This gave her an opportunity to explain what was going on and then we would talk about alternate ways of handling this situation. And then we would develop a treatment plan.</td>
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<td>Are there other techniques that you frequently use?</td>
<td>I would use large pieces of paper with multiple colors of crayons. So with these colors, whether they be crayons, chalk, markers, etc. I like to use some materials where colors can be blended. This is kind of an art/music therapy. This is kind of a play therapy. The instruction is given, “Choose a color and make a large circle on the paper”. And then after the circle is made, lay down the crayon and choose a color. Sometimes, we’ll do this exercise more than once because it’s takes awhile to get the feel for it. So choose a color, and inside the circle, put a shape. It can be a star, heart, rectangle, clock, locomotive, etc. Maybe it would turn out to be a bottle of booze. You want them to choose any shape they want. The next instruction is fill the center with a pattern or color. You don’t want to use music that</td>
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has a definite message. Then we talk about the pictures and we’ll see what we see and talk about what we see. We’ll look at the color combinations, the intensity of the colors, and the lines. It may look like they’re feeling comfortable today. I see a lot of warmth in your colors and blended colors. Or maybe they’re very jagged lines and intense colors, and there’s a lot of conflict.

Another thing we would use is dance therapy and we would use scarves. There would be a sequence that could be planned on. Maybe up and down 3 times, and back and fourth 4 times.

Is there anything else that you would care to share with me about play therapy with adult survivors?

We’ve used clay. We made maps. We have taken on some role playing in different ways. Let’s think of all the different roles we can play. This gives them permission to take on roles. We did some different dance therapies too. One of the things we do also is doing nursery rhymes. People with Alzheimer’s know the nursery rhymes. It’s a good spring board to get them talking about their childhood. We also acted out the nursery rhymes.

Comments:
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MASTER OF SCIENCE IN NURSING
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Human Services: Nursing
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1968 to 1990 Teaching, Administration, and Staff positions
Pine Rest Christian Hospital, Grand Rapids, MI
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