The Use of Play Therapy with Child Victims of Sexual Abuse

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Over three million children in the United States are reported to state child protection services as alleged victims of sexual, physical, and emotional abuse and neglect each year. Of these cases, approximately 903,000 are substantiated. Twelve percent of the substantiated cases involve child sexual abuse. This author provides an overview of the prevalence, risk factors, and symptomology of sexually abused children and critically examines the use of play therapy as an assessment and intervention tool.

Introduction to Child Sexual Abuse

Over three million children in the United States were reported to state child protection services as alleged victims of sexual, physical, and emotional abuse and neglect in 2003 (US Department of Health and Human Services, 2003). Of these cases, approximately 903,000 were substantiated. Twelve percent of the substantiated cases involved child sexual abuse (Kuehnle, 2003). Among males, the rate of sexual abuse is .4 per 1000; among females it is 1.7 per 1000 (US Department of HHS, 2003). While these abuse and neglect figures encompass children under age 18, over 50% of those children are below the age of eight. Childhood sexual abuse is clearly a pressing social problem.

Research suggests that national incidence figures may represent less than one-third of all occurring cases of maltreated children in America (Briere & Elliott, 2003; Finkelhor, 1994). This may be especially true for boys who are sexually abused, perhaps due to a stigma attached to their accounts. Incidents of child abuse during the preschool years are also likely to be underreported (Kuehnle, 2003). Further variability in national rates may exist because of the diversity of definitions that are employed by individual states. For instance, some states exclude child-on-child sexual abuse from their data. For the purposes of this paper, the definition of child sexual abuse will be that published by Cohen and Mannarino (1984), which defines child sexual abuse as “sexual exploitation involving physical contact between a child and another person. Exploitation implies an inequality of power between the child and the abuser on the basis of age, physical size, and/or the nature of the emotional relationship. Physical contact includes

anal, genital, oral, or breast contact" (p. 343).

Children are at an increased risk of sexual abuse when parents are unable to adequately supervise or nurture them, due to factors such as community or domestic violence, substance abuse, poverty, and single-parent status (Kuehnle, 2003). In a study by Straus, Gelles, and Steinmetz (as cited in Kuehnle), physical or sexual child abuse was found to occur simultaneously in 30 to 70% of two-parent families in which there was domestic violence. Other risk factors include early sexual maturation in girls and emotional and physical disabilities. Based on general population surveys, abuse by parents and step-parents constitutes between six and 16% of all cases, and abuse by any other relative comprises more than one-third of the cases. In clinical samples, parent figures comprise between one quarter and one third of the offenders, and all other relatives comprise approximately one half (Berliner & Elliott, 2002).

Symptomology of Child Sexual Abuse Victims

Sexually abused children may exhibit a wide range of potential symptoms, including low self-esteem, anxiety, depression, anger and aggression, posttraumatic stress, or dissociation. Much of the externalized emotional distress comes as a result of the children's level of hyperarousal, emotional pain, and restimulation of abuse memories; the abuse represents a constant challenge to their coping mechanisms (Berliner & Elliott, 2002). Thus, any external activity that successfully reduces internal tension (e.g., through distraction, self-soothing, or anesthesia) is reinforced and sought out by the child. According to Berliner and Elliott, negative manifestations of these behaviors include self-mutilatory activities; increased or precocious sexual activity; bingeing and purging; and alcohol or substance abuse. Some minors who have been sexually victimized exhibit school-related difficulties, including low time-on-task, acting-out behaviors, and low academic achievement. In a study of adults who had been sexually abused as children, Saunders, Villeponteaux, Lipovsky, Kilpatrick, and Veronen (1992) found that these adults suffered a wide range of psychiatric disorders and problems, including depression, phobias, obsessive-compulsive disorder, panic disorder, post-traumatic stress disorder, sexual disorders, and both suicidal ideation and suicide attempts.

Once sexual abuse has occurred, the child's functioning is likely to be more positive if the following conditions occur: the child is not closely related to the perpetrator; the child's mother believes the report and is supportive; the family is stable and without violence; the sexual acts were not violent in nature; and the child endured the abuse for a shorter period of time (Kuehnle, 2003). The child will also have an increased likelihood of long-term positive outcomes if he or she utilizes an active/social coping strategy – as opposed to avoidant, internalized, or angry strategies – and does

not blame him- or herself for the abuse (Kuehnle). Based on the significant impairment that sexual abuse poses to the psychological and behavioral outcomes of children and adults, it is obvious that effective intervention strategies are necessary at an early age.

Reviews of the treatment outcome literature provide evidence that abuse-specific cognitive behavioral treatments (CBT) are effective for the posttraumatic stress reactions related to child sexual abuse (Berliner & Elliott, 2002). Commonly, this therapy includes psychoeducation, which involves the provision of information about the nature of the abuse and offenders, in addition to anxiety management. Children are taught how to identify their emotions and how to use various relaxation and coping strategies. Elements from exposure therapy are utilized, involving the gradual exposure to the abuse experience in order to de-condition automatic negative associations and to reduce maladaptive avoidance. This is sought through talking, drawing, or writing about the abuse. Finally, cognitive therapy is "used to challenge and replace cognitive distortions about the event or generalized negative attributions about self and others" (Berliner & Elliott, 2002, p. 67). Parents can be included in this treatment with some positive outcomes related to child behavior problems and improved parental support. Other potential approaches for this population, such as family therapy, behavioral interventions, and pharmacological treatments, have yet to be thoroughly empirically evaluated for effectiveness in treating sexually abused children.

Another therapy that has not undergone empirical testing for use with sexually abused children but that may prove effective is play therapy. One reason that play therapy may be a particularly useful approach for sexually abused children is that they have not yet developed the abstract reasoning abilities and verbal skills needed to adequately articulate their feelings, thoughts, and behaviors. "For children, toys are their words, and play is their conversation" (Hall, Kaduson, & Schaefer, 2002, p. 515). Play provides a symbolic language that makes communication possible. This paper will provide an overview of play therapy and critically examine its role as an assessment and intervention tool with the population of child sexual abuse victims.

Defining Play Therapy

Play therapy is a general term used to describe a variety of interventions that incorporate the use of play into the assessment and treatment of children and families. There are two basic forms of play therapy: directive and non-directive. Directive approaches are those in which the therapist selects the activity and moves the child's play or discussion toward a specific topic or goal. This structured approach includes cognitive-behavioral play therapy, as described by Knell (1999). In nondirective, unstructured play therapy,

the therapist concentrates on establishing a relationship of unconditional acceptance of the child, within a safe environment, while the child is allowed to choose the play medium, set their own rules, and use the play objects and time as they wish (Guerney, 2001). Included in this category is the child-centered play therapy (CCPT) method developed by Axline (1969), based on the client-centered work of Carl Rogers, and non-directive puppet therapy (Carter, 1987).

Past Research on Play Therapy

In a comprehensive play therapy literature review by Phillips in 1985 (as cited in White & Allers, 1994), it was concluded that among 200 case studies, anecdotal articles, and empirical research reports that existed at the time, there were inconsistent definitions of play therapy, inadequate definitions of the qualifications and role of the play therapist, and inadequate or flawed statistical design. Based on the findings of this author's research and current literature review, 18 years after Phillips' analyses, the evidence related to play therapy appears nearly identical to that reviewed by Phillips, lacking well controlled-studies that could offer meaningful and informative statistics with which to empirically support the use of play therapy.

Rationale for Play Therapy with Child Sexual Abuse Victims

For the past 17 years play therapy has been regarded by numerous clinicians and researchers as a potentially effective intervention tool for use with child victims of sexual abuse. Regardless of the specific approach, most of the authors emphasize providing these children with a secure therapeutic setting in which the therapist shows support, acceptance, and perseverance. The authors also emphasize a setting in which the therapist acknowledges the thoughts and feelings expressed within the sessions (Carter, 1987; Kelly, 1995; Knell, 1999; McMahon, 1992; Singer, 1990).

Psychoanalytic play therapy, which incorporates both directive and non-directive approaches (Singer, 1990), aims to alter inner or outer functioning of the child by helping the sexually abused child understand his experiences and feelings. This occurs through the use of verbalization, interpretation, and clarification. A review of studies by Casey and Berman (as cited in Singer) "found good evidence that psychotherapy with children (compared to untreated controls) is at least as effective as with adults . . ." (p. 225). This supports the psychotherapeutic foundation on which child-centered play therapy is based. Consistent with the findings of Phillips, however, there is no indication that these studies had adequate sample sizes or that they utilized uniformed measurements. In a comparison study of parent therapy, play therapy, group therapy, and behavior modification for a cohort of children with a broad range of behavior problems, psychotherapeutic play therapy proved most effective for those children with internalizing

behaviors, such as depression, withdrawal, self-doubt, and fears (Singer). This could be promising evidence considering that these behaviors are consistent with those of many sexual abuse victims, as described earlier. Again, the term "psychotherapeutic play therapy" is used loosely, however, and it is impossible to surmise which aspects of the treatment were effective. The majority of support offered comes, instead, from individual case studies and anecdotes (Kelly, 1995; Singer).

Research related to both directive cognitive-behavioral play therapy and child-centered nondirective play therapy provides evidence to support the tenets on which they are based, but does not provide specific empirical evidence proving their effectiveness with sexually abused children. For example, Axline's nondirective approach is based on the empirical and clinical evidence demonstrating support for Rogers' client-centered methods. Likewise, in a study by Parpel and Maccoby (as cited in Guerney, 2001), a group of children whose mothers were taught to make supportive statements and to use nondirective approaches during play demonstrated more compliance than children whose mothers followed their own course (p. 14). This data offers support for the potential of child-centered play therapy but certainly does not qualify as empirical evidence to back this clinical approach.

Literature that devotes specific attention to the use of child-centered play therapy with sexually abused children is limited to case studies and anecdotal clinician and parent reports (Carter, 1987; Guerney, 2001; McMahon, 1992). By relaying examples from her own clinical practice, McMahon suggests a combination of nondirective and focused play techniques to be most effective with this population. She posits that the use of anatomically correct dolls is helpful both as an assessment and treatment tool, but provides no empirical evidence to back this claim. Suggested child-centered play therapy goals for the sexually abused child include the restoration of trust, the normalization of feelings, increasing feelings of control, expressing and coping with feelings of anger, fear, disgust and sadness, and enabling the eventual development of normal relationships of mutual sharing and care (McMahon).

Like child-centered play therapy, cognitive-behavioral play therapy is grounded in a body of research based on intervention strategies that have been proven effective with adults. Modeling, which is useful with adults (Bandura, as cited in Knell, 1999), is used to improve coping and as a means of psychoeducation with children; role-plays are used to practice problem solving skills and adaptive behaviors. According to Knell, "the fact that cognitive behavior therapies for adults have been empirically validated does not mean the same holds true for children" (p. 402). Her own evidence in support of cognitive-behavioral play therapy with sexually abused children is in the form of case examples.

Play Therapy as an Assessment Tool

Aside from the lack of empirical evidence to support the use of play therapy as an intervention tool, multiple authors recognize play as a vital means of assessing the sexually abused child (McMahon, 1992; Norton & Norton, 1997; White & Allers, 1994). Corresponding to the symptoms described previously, children who have been sexually abused may display developmental immaturity, opposition and aggression, withdrawal and passivity, self-destruction or self-deprecation, hypervigilance, sexuality, or dissociation during their play (Howard; Martin & Beezley; Terr, as cited in White & Allers, 1994). In comparison to a healthy child, the abused child may display a high level of intensity, atypical rigidity in play, or be overly dependent on the therapist for guidance in play. These play behaviors and themes have been shown to be valid and reliable means of identifying and assessing the sexual abuse victim. However, much of the research is based on small sample sizes and there is also a need for variables, such as hypervigilant and aggressive behaviors, to be defined thoroughly and consistently in future research.

Conclusion

Child sexual abuse is a disturbing problem within our nation – one that has serious behavioral and psychological ramifications for all involved. Play therapy, which may be directive, nondirective, or a combination of the two, is increasingly used for the clinical treatment of sexually abused children. Play therapy is the primary intervention model utilized by many social workers with children. Supporters of play therapy stand firm in their belief that this is an important clinical technique. Most of the research on play therapy and childhood abuse, however, has relied on non-statistical observations using single case or small-group samples. Just as Phillips (as cited in White & Allers, 1994) recommended 18 years ago, research deficits in the field must be addressed if therapists are to provide these children with effective care.

Now, and in the future, social workers will play a significant role in providing empirical research for the use of play therapy in the treatment of child sexual abuse victims. Statistical evidence is needed to show the effectiveness, or lack thereof, of play therapy with this population. Evidence is also clearly needed that compares the effectiveness of play therapy to other treatment modalities, including cognitive behavior therapy, family therapy, or nonspecific supportive therapy.

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