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CHAPTER 5

# Play Therapy as Early Intervention

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PRESCHOOL AND DAY-CARE centers frequently augment their programs by providing on-site therapies for children who need additional help. It is not uncommon for a Head Start program or day-care center to have a speech therapist on site to treat those children in the school community who have difficulty with communication. However, it is much less common for preschools to provide play therapy as a form of early intervention for children with emotional difficulties. This is true even in the face of increasing numbers of children with high levels of emotional distress. While early childhood professionals are generally quite knowledgeable about the importance of play skills in normally developing children, there is a general lack of sophistication about use of play as a therapeutic tool (Bratton, Ray, Rhine, & Jones, 2005).

Preschools that heal use play as a therapeutic modality serving as an integral part of the early intervention program for emotionally fragile children. This chapter will help readers become familiar with the play therapy process and create a context for including play therapy programs in the early childhood setting.

## PLAY THERAPY: DEFINITION AND HISTORICAL CONTEXT

Play therapy may be defined as a process of using play symbols to establish a connecting dialogue between child and therapist as well as between the child's conscious and unconscious experience. Play is the child's tool for making sense of his world, and children's spontaneous play is in part motivated by their need to interpret and master salient experiences. When developmental delays or traumatic events inhibit a child's ability to master personal challenges, a play therapist may intervene.

An antiquated system of social stratification may cloud our vision about the potential use of play therapy for today's urban children. Well-known case studies elaborating on successful treatments of very young patients have often featured upper-class children, such as Axline's (1964) *Dibs* and Winnicott's (1977) *The Piggle*. Indeed, the analytic community's early attempts to integrate the principles of child analysis with the practice of early childhood education resulted in therapeutic models that depended heavily on treatment via the parent. These early models primarily served well-educated, upper- and middle-class families through a highly verbal psychoeducational process. Parents were educated to be auxiliary therapists for their own children. The children themselves received a cognitively oriented early childhood experience designed to strengthen their verbal and perceptual skills, which would eventually allow them to participate in more conventional forms of treatment (Weil, 1972).

The evolution of psychologically oriented treatment programs designed to meet the needs of delayed, deprived, neglected, and traumatized children can be seen in the work of the corrective object relations therapists of the 1960s. The corrective object relations approach stressed the need for young children to experience their dependency needs in the presence of a responsive adult before age-level independent mastery could occur. Although programs informed by this approach were designed to meet the emotional needs of children, they were also found to positively influence a child's learning capacity. A project in Florida gave academically precarious first-graders weekly sessions where nurturing play was the primary intervention. The children's academic status subsequently improved (Brody, 1978). Likewise, Zelman, Samuels, and Abrams (1985) found that young psychotherapy patients often showed increases in IQ when tested following treatment. Arietta Slade's work on using play in therapy with young children who have not yet developed language and other representational capacities makes a compelling argument for the value of interactive, presymbolic, and early-level symbolic play as a therapeutic catalyst for a child's ability to create more complex and meaningful symbols that can help them integrate their experiences (Slade & Wolf, 1994).

While progressive early childhood education values young children's play and provides rich play opportunities in the classroom, children in classrooms designed to meet the needs of children with developmental and social-emotional issues are often treated as though their play behavior is not meaningful. Paradoxically, play is often less likely to be a welcome part of the schoolday for these children. Intervention objectives tend to be defined in behavioral terms, and the child's struggle to develop symbols that can hold and communicate his experiences is unattended. Given research findings indicating that play increases brain activity (Mann, 1996; Meade, 1999), the exclusion of play as a form of therapy and early childhood education for children at risk is puzzling.

Where does this leave us as we attempt to meet the special needs of traumatized and emotionally arrested urban preschool children today? Clearly, many of the children we see lack the verbal skills of "The Piggle" (Winnicott, 1977) and



fail to announce their intellectual potential via the IQ score, as Axline's (1964) patient *Dibs* was able to do. Many do not have parents who are physically or emotionally available to assume the role of therapist, as did the father of Freud's patient, Little Hans. Moreover, the children we see often show glaring developmental deficits or extremely disruptive behaviors that overwhelm the early childhood educator and the clinician alike. Trauma and deprivation act to create a kind of developmental paralysis in the child, sometimes preventing growth in several areas simultaneously. Unfortunately, this fragmentation in children results in programs that divide students into several pieces, each piece then becoming the province of the appropriate specialist.

Consider, for example, a little girl who was drug-exposed in utero, treated with intrusive medical procedures as an infant, and then removed from her mother and subsequently placed in two foster homes. At age 3, she displays high activity levels, delayed language development, fearfulness, and a detached quality of relatedness. She takes little initiative in manipulating her environment and does not follow through on the few activities she initiates. She can, however, dress independently, get her snack from the classroom refrigerator, and attend to her own toileting needs. Her early childhood program may refer her to a psychiatrist, who prescribes Ritalin for her activity level; to a speech therapist, who works on her delayed language; and to an occupational therapist, who improves her manipulative abilities. Yet no one is given the job of helping this fragmented 3-year-old integrate all of these disparate approaches, let alone helping her make sense of the real-life experiences that have impacted on her so tragically. Neither is there an assumption that this child's life experiences might have diminished her developmental processes, and that attention to the emotional injuries sustained might improve her developmental outcome.

When we ask this little girl's teacher whether she might benefit from play therapy, the teacher reacts with surprise. "But she doesn't know how to play!" the teacher replies.

## CHILDREN WHO CAN'T PLAY

There are children who do not know the language of play. They come to preschool but cannot participate in the bubbling of creative activity surrounding them. Sometimes they remain silent, sullen, and preoccupied, maintaining a hypervigilant stance and refusing to allow themselves to become involved in the preschool world except to assume an almost precocious responsibility for their own self-care. Indeed, studies of deprived children in preschool identify a pattern of precocious self-care activity coexisting with impoverished cognitive and language development (Koplow, 1985; Pavenstedt, 1967).

Some children appear active within the confines of a world they seem to fill with rituals and idiosyncratic manipulations of the environment. Their "play"

seems to lack the rich quality of personal interpretations and variations that characterize the drama in most housekeeping corners populated by 4-year-olds. Peers do not understand the meaning of their rituals and, therefore, do not seek to join in. Adults are confused by the unusual quality of the child's activity and may conclude that they do better with structured, task-oriented work.

### Play, Language, and Trust

Many children who cannot play are also unable to use language effectively (Greenspan & Wieder, 2006; Westby, 1980). Some of these children are extremely volatile emotionally, expressing distress through frequent bouts of crying or violent outbursts. Children who cannot play may seem highly disorganized in the classroom environment. It is as if they are unable to orient themselves to the routine or to differentiate between one classroom area and another. Others may appear to organize themselves quite effectively by staying involved exclusively with structured materials, such as puzzles or pegboards, because these toys have a single purpose and do not require peer contact, communication, or personal elaboration.

If children come to preschool and are unable to speak at age level, they are referred for language therapy. If children come to preschool and are unable to play at age level, there is a tendency to lessen their opportunity for play instead of implementing therapies that will enhance this essential ego function.

"If we have toys, the children will hurt each other! They will become overstimulated! They will play about scary experiences and become upset." These comments illustrate the fears of urban teachers who are given the task of containing many emotionally fragile children without the benefit of play as an expressive outlet or form of emotional release.

How can nonplayers learn the language of play so that their own self-generated activity can become meaningful and promote growth? And how can traumatized children, whose play may consist of a grim repetition of traumatic events, come to use play as a healing process? Play therapy may be indicated for children in both categories.

Winnicott (1971/2005) tells us that the ability to play implies trust in the maternal environment. In order for play to develop, children must be able to rely on their primary caregivers to ensure their safety and meet their basic needs. The well-protected and well-nurtured child is then free to devote her emotional energy to her own developmental processes. She can interact with her environment playfully and explore her impact without the burden of having to guarantee her own survival. She can depart from the present qualities that her play materials may possess and fantasize about new and interesting possibilities. She does not fear losing touch with her primary caregiver as she plays because the caregiver has helped her give names and definition to her playthings, and therefore these playthings have become endowed with meaning and meaningful connections to the nurturer (Siegel, 1999; Stern, 1985/2000).



Many children who cannot play are children who have had to attend to their own survival needs. They cannot afford to take their attention from the here-and-now mission of staying alert to danger, obtaining food, tracking the adult, preventing abandonment, and competing with other children to collect mountains of materials that, sadly, fail to satisfy them because the toys are empty of maternal connection. It is often next to impossible for these children to involve themselves in abstract conceptual tasks, or play themes, because survival is felt to be dependent on maintaining a vigilant state. This tends to result in a diminished use of fantasy play or in fantasy invested as the only escape from the survival burden, thus compromising reality testing and making it difficult for the child to return easily to the present. Recent studies have highlighted the role of opportunity for stable adult–child interaction in the development of reality testing (Greenspan & Wieder, 2006). Therefore, in order to learn the language of play, children's needs for protection, nurture, and interaction must be met. Emotionally fragile children may require an individual relationship with a therapeutic adult in order to experience their dependency needs without overwhelming the group. The child's relationship with the therapist may become a pivotal catalyst in the development of play symbols, as he searches for ways to represent his experiences with the therapist.

### A Space for Play

A play therapy space needs to be a safe, clean, and predictably accessible. It should be neutral, meaning it should not have other uses for those children being treated. Toys should be intact and well cared for and should either be items that convey the nurturing and containing features of the therapeutic relationship or items that lend themselves to becoming symbolic of children's actual and inner experiences. For example, available materials for preschool playrooms may include the following:

| | | |
|---|---|---|
| dolls | Russian dolls | fire hat |
| doll houses | bubbles | miniature firetrucks |
| little people | children's books | police figures |
| play food | sand, cornmeal | ambulance |
| playdough | hospital figures and paper | animal puppets |
| crayons | people puppets | baby bottles |
| chalkboard | mirror | a potty |
| marker board | play telephones | disposable diapers |
| pillows | dress-up items | a space for children to hide |
| blankets | a doctor kit | |

Play therapists should keep in mind that material need not be limited to those typically suited for preschool age levels; many children using the space will be

trying to resolve earlier developmental issues that were disrupted by difficult experiences. Materials such as lotto games, peg boards, and electronic toys are not recommended because they discourage interpersonal relatedness and do not facilitate representational play.

Traditional psychoanalysts have considered the child's imposition of order in the room to be part of the therapeutic process and, therefore, have not always attended to arrangement and position of materials. However, when treating children who have experienced chaotic living situations, including disruptions and multiple separations from caretaking environments, it is important for the play therapist to maintain a more organized space (Donovan & McIntyre, 1990). For example, instead of having one large toy box containing a variety of toys, the therapist should separate items thematically and locate similar items in distinctive places in the room. For example, all dolls may be kept in the doll bed, crayons and paper on the shelves, play food and play dishes in the cabinet, and so forth. This enables the children to consistently find materials when they seek them out and shows them that the therapist respects their investment in the therapy space. This is particularly important for children whose achievements of object permanence and object constancy may be tentative.

## PLAY THERAPY: PERSON AND PROCESS

Who is the child that is an appropriate referral for play therapy?

Preschools should be aware of children who show extreme separation anxiety, maintain a preoccupied hypervigilant state, elect to be mute in the school setting in contrast to demonstrated verbal ability elsewhere, show extreme fearfulness or social withdrawal, do not show age-level ego development in spite of adequate cognitive ability, have language that is atypical and noncommunicative, do not develop fantasy play, or remain absorbed in constant fantasy and appear to lose their orientation to the present reality. Complete developmental histories should be taken during the preschool intake process, and children who have suffered the death of a parent or sibling, been a victim of abuse or neglect or other traumatic experiences, been affected by family or community violence, been hospitalized for illness and treated with intrusive medical procedures, or sustained long-term or multiple separations from caregivers should be considered for play therapy programs whether or not they are symptomatic. Children who have had these experiences are at great risk for emotional, developmental, and learning difficulties, and play therapy may prevent the evolution of more serious problems as they grow older.

Teachers are usually quick to point out those children in the classroom with the most disruptive behavior as likely candidates. Indeed, these children may be acting out psychological needs that they are unable to express verbally. However, there are also children who may not manifest distress through aggression. Preschools should be aware of traumatized children who may be driven to reenact traumatic experience through grim and repetitive play. Their behavior may seem unremarkable except for high levels of distraction and a preoccupied state. These children may show delays in overall development, indicators that the trauma caused developmental arrest.



Young children initially use toys as "transitional objects" that represent the caregiver and allow the child to move out of her sight. This can be considered a precursor to more complex symbolic play. It follows that children who have relatedness difficulties or attachment disorders typically lack transitional objects and show delayed ability to elaborate in play. Toys may have idiosyncratic uses, and dynamic features tend not to be perceived. While these children may not act out in an aggressive manner, play therapy may be indicated as a preferred intervention method.

Play therapy may be accomplished by professionals from a variety of disciplines. Interviews undertaken for this book found play therapy programs implemented by clinical social workers, school psychologists, clinical psychologists, and counselors, as well as by special educators and early childhood educators trained in play therapy technique and supervised by mental health clinicians.

Play therapists treating young children must have a deep understanding of child development in order to recognize unresolved developmental issues and address them using therapeutic technique. Play therapists must have the capacity to be with children who have sustained developmental and psychological injuries without becoming overidentified with the child's fragility. Attempts to deal with this problem sometimes result in the therapist usurping the maternal role or, at other times, assuming a defensive distancing in working with the child.

### Clinical Premises and Methods

Clinical philosophies and methods vary considerably and range from nondirective approaches in which the therapist maintains a neutral stance and supports the child's unfolding themes (Axline, 1964), to approaches where the therapist directly nurtures the child using food, holding, and so forth (Alpert, 1963; Brody, 1993), to approaches where the therapist considers interpretation her primary task (Freud, 1926/1965; Klein, 1932). More recent work has focused on the value of the interactive play partnership as a springboard for the development of symbolic and social capacities (Greenspan & Wieder, 2006; Slade & Wolf, 1994). Certainly, the avenues of treatment will vary according to the background of the therapist and the need of the child (see Chapter 6). Yet there are some developmental premises that inform therapeutic work with young children and can be discussed apart from the particular method employed.

One such premise is that an individual relationship with a therapist will provide an organizing experience for a young child, whether or not the therapist is active in the play and assumes a role of alter ego or is neutral and reflective in her

manner. The special relationship and the special room that contains it may constitute a psychological home base for children who have been unable to internalize a primary relationship.

Another important premise is that materials in the therapy room will become endowed with meaning born of the therapist–child relationship. This will eventually allow the child access to underlying issues and enable the child to share these issues with the therapist through the use of play metaphor. Once the troublesome material can be shared or worked on, the child will experience less anxiety and will be more available for social interaction and learning.

A third premise is that children who are preoccupied with survival issues or with traumatic experiences will not be able to attend to structured teacher input. Their energy will be spoken for in the cause of their own survival. In the case of trauma, children may be tense with the effort of holding overwhelming experiences at bay or may be flooded with intrusive sensory remnants of the traumatic experience. Therefore, in order to address these children's difficulties, the play therapy process allows children to attend to their internal preoccupations and dramas before requiring them to take in new information.

Finally, while play therapy technique was traditionally thought to be appropriate only for children whose symbolic processes are well developed, this author also advocates its use for children who need to build a developmental bridge from sensorimotor, ritualistic, or idiosyncratic play to a representational play level.

## A Case in Point: Dionne

Dionne was 2 years old when her mother was killed by a stray bullet when they were entering their project building.

At 2½, when Dionne's pediatrician sent her for intervention, the trauma and loss were part of her record, but the developmental delays that occasioned the referral were presumed to be related to Dionne's mother's drug history. Indeed, Dionne's grandmother spoke sadly of Dionne's unusual and arrested development during the nursery intake, describing a nonverbal, withdrawn child who rocked to soothe herself and who had violent outbursts with no obvious provocation. Dionne did not play with toys and showed little interest in her environment. Dionne's grandmother initially presented a positive picture of her granddaughter's life prior to the murder but later acknowledged that she had been worried about the quality of Dionne's care from the beginning. She told of coming to visit and finding Dionne dirty and neglected. She feared the neglect might have been a sign that her daughter had become increasingly involved with drugs.

In the classroom, Dionne was either withdrawn and glued to a tiny rocking chair or highly anxious and in constant motion. She often panicked if anyone came to the classroom and stood in the doorway conversing with the teachers, screaming for her grandmother and becoming inconsolable if her screams did not immediately bring Grandma from the parent room.



After some months, Dionne internalized the classroom routine and became slightly less hyperactive, although the panic attacks continued. Her language became more elaborate, and she began to use short sentences as well as single words and phrases. Her play consisted of driven doll-nurturing, which was done in a serious, painstaking, and almost desperate way. The worried, empathic care shown to her baby doll was in sharp contrast to Dionne's demeaning treatment of her own mirror image. She frequently accosted herself in the mirror with angry language. "You're disgustin'," she would yell at her own mirror image. "You're sickenin'."

Dionne's teacher noted that while she became toilet-trained after her first few months at school, Dionne became anxious and hyperverbal while sitting on the toilet, often making odd associations that were difficult to follow.

Dionne's play therapy sessions allowed her to clarify her complex feelings about caretaking, toileting, and mirror play and gave the staff insight into the issues that preoccupied Dionne and took her away from the work of developing her own ego capacities. In addition, the play therapy time provided Dionne a forum for exploring sensitive material related to her loss that may have been disruptive to other children if enacted in the classroom.

The following session recording will help the reader understand how the process of play therapy might unfold with a young child, and how unresolved developmental issues may be reworked when the relationship supports a heightened level of receptivity in the child.

### Beginning Phase

Dionne has been in the classroom program for 6 months and has undergone 3 months of treatment. At the moment, she is cooking for her baby. She speaks to the therapist in a demanding tone.

DIONNE: Sit down. You're the daughter. (*softly, to her baby doll*) Here, poo, here your food. You don't want more? Okay. (*She feeds in a very realistic manner, looks up and sees the therapist looking at her.*)

DIONNE: Don't look at me. I told you.

THERAPIST: You don't like me to look at you?

DIONNE (*loud and demanding*): I told you. Eat your food. (*The therapist eats and gives Dionne the empty dish.*) Go to sleep, then, there! (*Dionne points to a pillow on the floor. The therapist pretends to sleep by closing her eyes and lying on the floor. Dionne cuddles her baby and then softly puts her into bed and spends several seconds adjusting her blanket. She catches a glimpse of herself in the mirror.*)

You stupid! (*The therapist opens her eyes and looks up at Dionne.*) Shut up, you're lookin' again.

THERAPIST: I woke up and I heard you call the mirror of Dionne stupid. You don't like me to look at you, and you don't like to look at yourself either.

DIONNE: Shut up.

### Two Months Later

Dionne is calling Grandma and several of her cousins on the play telephone, standing and talking in front of the mirror. She alternates between dialogue with the party on the other end of the phone and her mirror image.

DIONNE: Hi, how are you doing? Yeah? (*to her mirror image*) You disgustin'! You fucker, get out of here! (*to the phone*) Grandma, just a minute. (*She looks at the therapist.*) I gotta pee.

THERAPIST: Okay, tell Grandma you'll be back in a minute. (*Dionne and the therapist go out to the bathroom, where Dionne announces that she needs to "doo-doo" as well. She is very ambivalent about the therapist's presence in the bathroom, screaming, "Go away," but instantly calling her back the moment she leaves.*)

THERAPIST: You want me to stay with you for the doo-doo, but you're scared for me to see.

DIONNE: I'm scared. (*She finishes and returns to the room. She sees the telephone off the hook.*) Oh, Grandma! (*She picks up the phone.*) Hi, I came back, I didn't do no doo-doo, nope, okay, bye.

THERAPIST: You told Grandma you didn't do a doo-doo, even though you did. Maybe you're scared for Grandma to know about that.

DIONNE (*very anxious*): I want Grandma, I want Grandma, come on. [Dionne's grandmother is in the parent's room downstairs.] See Grandma, see Grandma! (*Dionne starts screaming. She becomes more and more agitated, and it is close to the end of the session.*)

THERAPIST: Okay, we'll find Grandma. But somehow I think you're scared that doo-doo will make Grandma go away. (*Dionne pulls the door open and rushes down the hall with the therapist close behind her.*)

### Six Weeks Later

Dionne says nothing. She goes to the baby bed and awakens her baby, getting several accessories from the shelf, including a brush, a pocketbook, Pampers, and so forth. She brings it all to the other side of the room as if she plans to use the closet for a make-believe destination. In passing, her eye falls on the baby potty that has always been in the room.



THERAPIST: Is your baby big enough to use the potty? (*Dionne abandons her mommy role instantly, drops the doll and other items on the table, and plops herself into the potty seat, giggling.*)

DIONNE: I'm going to pee on myself.

THERAPIST: If you sit down, you feel like you have to pee?

DIONNE: For real, I'm going to pee in this potty. I can?

THERAPIST: You can if you want to; it's up to you.

DIONNE (*pulls her overalls off, sits down, and begins to urinate*): Oh, doo-doo, doo-doo's tryin' to come out, too.

THERAPIST: Do you want to make doo-doo in the potty, too?

DIONNE: It's coming, it's coming out.

THERAPIST: All right, we'll wait for it to come.

(*Dionne watches in amazement as she fills the potty. She becomes anxious about not having toilet paper but accepts tissues from the therapist, and then fixes her clothes. She stands staring at the potty.*)

THERAPIST: Let's take the potty to the bathroom like in the story of "Once upon a Potty." (*This is a story Dionne has often read. The therapist and Dionne do this and carry out the ritual of parting from its content according to the script of the familiar story.*)

DIONNE: I made doo-doo in your room. (*looks at the therapist with disbelief*)

THERAPIST: You made doo-doo in my room, and it was okay. I stayed right here; I didn't go away. (*Dionne shrugs, giggles, and is unsure of what to do next.*)

THERAPIST: Sometimes you play like you're a mommy of a little baby, and you take such good care of her. Sometimes you play the mommy of a bigger daughter, and you get angry and yell. Today you were little. You made doo-doo on the potty like someone very little who's just learning.

DIONNE: Yeah, yeah, I'm a baby, give me a bottle.

(*The session continues with Dionne playing baby and asking the therapist to nurture her.*)

### One Month Later

Dionne is looking in the mirror. She is always well dressed by her grandmother and seems to be seeing something pleasing to herself today. She smiles but says nothing.

THERAPIST: It looks like the mirror Dionne is looking good today. (*Dionne smiles.*) I've got some paper bags for puppet making. I brought these so we can make a story about Mommy K., Dionne, and

Grandma. (*Dionne looks suspicious. She takes a bag and lets the therapist show her how to make a puppet.*)

DIONNE: Make Grandma.

THERAPIST: Okay, I'll make Grandma and Mommy K., and you make Dionne.

DIONNE (*makes a face on the bag*): That's Tina. [Tina is Dionne's cousin.]

THERAPIST: We're not playing about Tina, only Grandma, Mommy K., and Dionne. You can make two Dionnes, though. Dionne like now, 4 years old, and little Dionne, only 2 years old.

DIONNE: I make little Dionne.

THERAPIST: Let's pretend little Dionne is in her crib, waiting for Mommy K. to change her diaper.

DIONNE: Oooh, she made doo-doo?

THERAPIST: I don't know.

DIONNE: Yep, her did.

THERAPIST: But, remember, little Dionne is only a baby. She doesn't know about the toilet yet. She needs her mommy to help her.

DIONNE: Why her mommy ain't coming?

THERAPIST: I don't know. Dionne needs a new diaper, and Mommy's not coming.

DIONNE (*pointing to little Dionne*): Her disgustin'.

THERAPIST: Maybe you think Mommy didn't come to take care of little Dionne because of the doo-doo. But Grandma says that Mommy K. forgot things sometimes. This time she forgot about little Dionne. Dionne is sad and worried.

DIONNE: She worried. Where's Mommy K.?

#### Some Weeks Later

The therapist has made a doorway from cardboard to use with the puppets.

DIONNE: What's that?

THERAPIST: We need this to try to understand about what happened to Mommy K.

DIONNE: Mommy K.? No, Mommy Grandma.

THERAPIST: Mommy K. was your mommy, and later after Mommy K. died, Grandma came to take care of you, and now she takes care of you like a mommy.

DIONNE: Mommy Grandma.

THERAPIST (*using puppets*): Look, Dionne and Mommy K. are in the doorway, walking through the door.



DIONNE (*screaming*): No, no! (*She hugs Mommy K.'s puppet.*) No, no, it's blood! (*She is agitated.*)

THERAPIST: The gun went bang and shot Mommy K., and there was blood, and it was so scary for Dionne. Look, some people are coming to call the ambulance to take Mommy K. to the hospital.

DIONNE (*gets the doctor bag*): Her better.

THERAPIST: The doctor tries to make Mommy K. get better, but they can't. It was so sad.

DIONNE: Mommy K. died, but then the doctor made her better, and now she's Grandma.

Clearly, at this point Dionne still has major confusion about the death of her mother and will need to keep working on sorting out her complex emotional experiences. However, play therapy illuminated some of the personal meaning that Dionne had attributed to her loss and allowed her to rework developmental issues that were paralyzing her. She was able to separate past from present enough to feel secure in the school setting, and the panic attacks diminished. As issues of self-image, nurture, autonomy, and loss received more therapeutic attention, they preoccupied Dionne less completely in the classroom setting, and she became a more verbal, more receptive child. Dionne's IQ was 30 points higher when she left the program at age 5 than it was when she entered the program at age 2½.

## CONCLUSIONS

When play therapy takes place within the context of the early childhood program, children are able to experience attention to their dependency needs and use relationships to deepen their symbolic capacities. This allows them to use play to resolve difficult developmental and life experience issues, and to do so in the company of an attuned adult who can bear witness to their struggles and their growing integration. Parents may feel relieved to know that their children's emotional difficulties can be addressed in the trusted and familiar school setting. Indeed, given the lack of mental health care options for most young urban children, play therapy made available to preschool students may constitute a powerful form of preventive intervention, giving children a crucial opportunity to heal potentially paralyzing psychological wounds before the heavy doors of elementary school are pulled open.

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