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CHILD DEVELOPMENT

A PRACTITIONER'S GUIDE

Third Edition

DOUGLAS DAVIES

Series Editor's Note
by Nancy Boyd Webb

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tend to choose black images (Cameron, Alvarez, Ruble, & Fuligni, 2001). Further, when the research procedure is changed and children are not forced to choose a preferred image, or assign positive or negative connotations to different images, young children show interest in Asian, white, and black stimuli and do not spontaneously judge the images different from themselves as negative. Instead, "Children tended to evaluate out-groups favorably when they were not forced to choose between them and their own group" (Kowalski, 2003, p. 687). Although older children, influenced by social context, may take on racist attitudes, preschoolers tend not to show racial prejudice. They may *prefer* their own group, but they do not *reject* others on the basis of race (Brewer, 1999).

How race and ethnicity are integrated into the young child's developing sense of self depends a great deal on socialization within the family. A majority of African American parents, for example, offer their children positive messages about African American culture, identity, and pride. Young children exposed to these socialization practices have better problem-solving abilities, more factual knowledge, and fewer behavior problems (Caughy, O'Campo, Randolph, & Nickerson, 2002; Hughes et al., 2006).

A practice implication of the preschool child's integration of racial and ethnic identity into the sense of self is that therapists should have human figure toys that reflect their child clients' racial identities, just as one includes female and male figures. To fail to do so conveys a subtle message that the child's identity is invisible or unimportant.

APPENDIX 9.1. SUMMARY OF PRESCHOOL DEVELOPMENT, 3–6 YEARS OF AGE

Overall Tasks

- Development of play as a vehicle for exploring reality
- Make transition from view of world based on egocentric and magical thinking to a more logical and reality-based view

Attachment

- Attachment continues to provide security when child is under stress (3–6 years)
- Attachment needs are frequently verbalized rather than simply being expressed in action (4–6 years)
- Improving memory and sense of time allow child to cope with separations—the child can understand better when a parent will return (4–6 years)
- Working models of attachment are firmly established and can be generalized to relationships with nonparental caregivers and peers (3–6 years)

Social Development

- Development of social skill through interaction and play with peers; social competence gradually develops through peer interactions involving negotiation about play scenarios, conflicts based on egocentrism and possessiveness, and triangular dynamics involving competition and exclusion (3–6 years)
- Development of verbal approaches to social interaction and conflict resolution (4–6 years)
- Prosocial interaction is elaborated and more frequent, based on increasing identification with adult models and growing skills in empathy and perspective taking (3–6 years)
- Exposure to peer group and prosocial values in preschool settings encourages cooperation, sharing, and problem-solving skills (3–6 years)
- Peers become more important; sustained exposure to peers leads to decreases in egocentrism; the preschooler identifies with peers and is motivated to make interactions with them pleasurable (4–6 years)
- Friendships based on common play interests develop (4–6 years)

Language and Communication

- Vocabulary at age 3 equals about 1,000 words and continues to increase at a rate of about 50 words each month (3–6 years)
- Speech becomes clear and easy to understand in most preschoolers (3–4 years)
- Long, grammatically complex sentences involving 8–10 words and dependent clauses are typical of the speech of preschoolers (4–5 years)
- Out-loud self-talk, or private speech, accompanies behavior and play; the child describes and directs his behavior in this way (3–5 years)
- Interactive play increasingly depends on language (4–6 years)
- Language gradually supplants action as the child's primary means of communication (4–6 years)

Symbolic Communication and Play

- Preschooler's play tends to be imaginative, dramatic, and interactive (3–6 years)
- Functions of preschool play: exploration of reality and social roles; mastery of stress; expression of fantasies, wishes, and negative, forbidden, or "impossible" impulses (3–6 years)
- Distinction between real and pretend becomes increasingly clear as the preschool period proceeds; play, which children understand is pretend, helps them begin to distinguish between fantasy and reality (4–6 years)
- Play provides opportunities for practicing emerging cognitive skills, including cause-and-effect thinking, construction of narrative, perspective taking, problem solving, and exploring alternative interpretations of reality (4–6 years)

Cognitive Development

- Generalization and thinking in categories increases (3–6 years)
- Improving memory provides a greater knowledge base for categorizing new information; at the same time, a wider range of categories for information storage increases the chance that the child will remember new information (3–6 years)
- Increasing cause-and-effect thinking leads the preschooler to look for causal connections between events; however, limitations in the ability to think logically or emotional arousal may lead the preschooler to mix up cause and effect (4–6 years)
- Egocentric thinking persists, causing limitations in the accurate understanding of reality; types of egocentric perceptions include the following: inability to assume another's perspective; reversal of cause and effect; attributing the causes of events to the self; transductive reasoning; personalism; animism (3–6 years)
- Magical thinking and the fusion of fantasy and reality are common, especially when affective arousal, as in trauma, influences thinking. In situations where there is need for "hidden" information, such as figuring out how a seed becomes a plant, the preschool child is likely to utilize fantasy as a way of trying to explain reality (3–6 years)

Self-Regulation

- Increasing ability to categorize experience reduces sense of novelty in new situations, resulting in feelings of control and less vulnerability to anxiety (4–6 years)
- Cognitive ability to imagine and anticipate the consequences of behavior contributes to improving impulse control; this ability is increasingly supported by the child's internalization of social expectations (4–6 years)
- Inner speech and private speech are used to sort out experience and provide reminders of rules, prohibitions, and expectations (3–6 years)
- Ability to displace real-world concerns and anxiety into fantasy play and other forms of symbolic expression (3–6 years)
- Internalization of dyadic strategies of regulation: working models of dyadic regulation are generalized to self-regulation (3–6 years)
- Beginnings of conscious inhibition of emotional expression and arousal (4–6 years)
- Psychological defense mechanisms: projection, displacement, denial, regression (3-6 years)

Moral Development

- Gradual internalization of moral values, resulting in the establishment of a conscience or superego by about age 6 (3–6 years)

- Increased self-monitoring: Older preschoolers monitor their behavior, applying standards of morality to themselves; however, this is not done consistently (5–6 years)
- Guilt develops as a distinct emotion (4–6 years)
- Rule-governed behavior: With reminders and reinforcement, preschoolers can follow the rules at school or home; however, they have difficulty abiding by the rules of a game, in part because they cannot emotionally tolerate losing, and in part because the fantasies that games evoke seem more important to them than the rules (4–6 years)
- Increasing importance of peer relationships helps children control negative or impulsive behavior because they want to maintain the friendship and approval of peers (4–6 years)
- Moral controls are gradually internalized by age 6 through the following influences: consistent parental monitoring, limit setting, and praising of good behavior; increasing parental expectations as the child's capacity for self-control matures; identification with parental values; increasing capacity for empathy; increasing peer orientation (3–6 years)

Sense of Self

- Self-esteem is supported by child's growing sense of competence, autonomy, and coping abilities (5–6 years)
- Preschool children who have received parental love and support over time tend to have a positive view of self (5–6 years)
- Identification becomes a basis for defining the self; children consciously strive to be like their parents and also unconsciously assimilate parental characteristics (3–6 years)
- Positive identification helps allay the child's anxiety about being small and incompetent relative to adults (4–6 years)
- Gender identity: Children demonstrate increasing awareness of gender identity and culturally based sex roles in play and peer relationships (3–6 years)
- Sexual sense of self: During the preschool years sexual interests develop, as manifested in preoccupations with the body, increased masturbation, Oedipal interests, and curiosity and anxiety about sex differences (4–6 years)
- Racial identity: Minority children are aware of prejudicial racial stereotypes; the impact of this awareness for self-esteem, however, depends on whether minority children have experienced the positive processes contributing to self-esteem described above (5–6 years)

CHAPTER 10

Practice with Preschoolers

ASSESSMENT

Preschool children are more autonomous than toddlers. They can express themselves in play, art activities, and words. Consequently, assessment approaches that combine parent–child sessions and individual sessions with the child are both possible and useful. In individual sessions a preschool child may be able to represent her concerns in play more freely than with her parent present. As always, assessment must consider all of the developmental domains. Areas particularly useful to observe in the assessment of preschoolers are cognitive processes, play ability, and self-regulation. Children who have difficulties controlling impulses during the preschool years are at risk for problems in social development. Cognitive processes should be observed with an eye to possible distortions of experience based on egocentric thinking. Since play supports so many aspects of preschool development, it is important to investigate the child's capacity to use play to create stories, represent ideas about cause and effect, and organize her view of reality. Children who are inhibited in their play may need help to express themselves more freely. Children who are impulsive or have attentional difficulties may benefit from interventions that help them organize their play. The child whose problems with attention, concentration, and impulsivity interfere with play development does not get the practice with organizing the world and thus may be less prepared for more advanced forms of thinking that build on play thinking.

Observation in the Child Care Center as an Assessment Strategy

In addition to play sessions and family interviews, assessment of preschoolers often includes observations of children in child care settings and consultation with child care providers. Over 60% of children 4 and under in the United States are in regular child care (Shonkoff & Phillips, 2000). Mental health

referrals of young children often originate from the observations of child care providers who interact with them on a daily basis. Mental health practitioners must broaden the traditional context of agency-based assessment to include observations of children in their home and child care environments.

The child care center's importance in the everyday lives of families points to its potential as a site for prevention and early intervention efforts. Because child care personnel see so many children, and are therefore familiar with the range of normal expectations for a given age, they often are the first to raise questions about developmental delays. Child care providers are in a position to observe how a child and parent(s) are managing stresses on the contemporary family, because the child's reactive distress usually shows up in behavior at the center. They can observe how the child and parent(s) are handling life transitions, such as the parent's return to work or school, or the disruptive period following separation and divorce. They can see when negative interactions between parent(s) and child are developing, and they can look for signs of abuse or neglect. They can offer emotional support to those parents who are isolated, and they can provide information about child development, discipline, and other parenting issues. Since they often spend 20–40 hours weekly with a particular, child who often will have developed an attachment to them, they are also in a strong position to intervene on the child's behalf (Johnston & Brinamen, 2006).

CHILD CARE CONSULTATION WITH A PRESCHOOL CHILD: A CASE EXAMPLE

The director of a child care center where I had previously consulted regularly asked me to assess Carlos, a young 3-year-old who had been at the center the previous year and had just returned from a 2-month-long break during the summer. Shortly after his return to school his teachers noticed that he was becoming increasingly withdrawn and silent. Both parents worked, and Carlos was in care approximately 35 hours per week. Carlos's teachers were concerned because of his lack of involvement with peers and his seeming mutism. Carlos was a bilingual child who had been exposed to both Spanish and English since birth. During the preceding year, between ages 2 and 3, he had been speaking in school somewhat, and his use of English seemed adequate for his level of development. His play had been more parallel than interactive. Because he was still 2, his teachers had not been concerned. He talked at home and showed no evidence of language delays. His mother, Ana, was from Panama and spoke Spanish to him at home. His father, John, was American and fluent in Spanish, and he alternated between Spanish and English in speaking to Carlos. The parents felt that Carlos's English was as good as his Spanish and did not think his failure to talk at school was related to lack of knowledge of English or anxiety about speaking English.

My first thoughts were to observe Carlos at the center to try to learn if

there were specific factors in the environment that might be inhibiting him from interacting. I also wanted to see how Carlos functioned at home. The descriptions of his talking at home, but not at school, suggested selective mutism. By seeing him at home, I could directly observe his use of language.

Observation at the Child Care Center

Carlos watched the other kids silently but did not interact with them. He stood in a fixed position for surprisingly long periods of several minutes, just watching, with a rather blank look on his face. It was as if his body was mute like his voice. Nevertheless, his eyes showed interest and moved as he watched other kids. Other children tended to pass him by as if he weren't present. They had already learned not to expect interaction with Carlos. A girl brought a picture of a polar bear to show Carlos; she said something I couldn't hear. Carlos glanced at her, then at the picture, and the slightest whisper of a smile came over his face and disappeared. He did not say anything, and the girl moved away. Seeing that Carlos's eyes carefully followed the activities of other kids helped me imagine that he was not simply detached or alienated. His eyes seemed to express interest and curiosity, despite the apparent withdrawal communicated by his blank facial expression and his almost frozen body posture.

Home Visit

Carlos was friendly toward me, though a little shy, and he spoke to me in English. His language skills seemed appropriate for age. He showed me his toys and talked while he drew pictures. During this visit Carlos's mother, Ana, conveyed an eagerness for help and spoke with me openly. Ana told me that she'd been homesick since her summer visit to Panama. She had lived in the United States for 4 years and complained that she still did not feel at home, though she preferred to stay in the United States because of work opportunities for herself and her husband. She said that Carlos missed their large extended family in Panama. I asked about other stressors currently affecting Carlos, and she could not think of any. She said that she had discussed Carlos's problems at school with her *compadres* in Panama, but reflected that they did not know how to help because they were unfamiliar with life in the United States. I asked if she felt comfortable talking with the child care staff in Carlos's room, and she named one teacher, Lisa, whom she felt was concerned and sympathetic.

Impressions

Carlos had the characteristics of a selectively mute child. These children have normal language development and speak at home, but tend not to speak outside the home. Children who are shy or temperamentally slow to warm up are more likely to develop this problem, as are children of immigrants (Toppelberg et al., 2005). I wondered if Carlos's mother, out of her own discomfort with American culture, may have conveyed to Carlos that the child care center should be an uncomfortable place. In this context, it would have been helpful to observe a drop-off or pickup to see how she interacted with Carlos's caregivers. Even though he was only occasionally resisting going to school, I speculated that he felt insecure being separated from his mother, perhaps because he had internalized some of her discomfort with American culture and her anxiety over separation from her family in Panama.

Since ages 3–4 is a crucial period in social development, when children begin to interact with peers more intensely, I was concerned that Carlos was missing out on learning skills in sharing activities, play, and ideas, and that his inability to enter into peer interactions would, over time, reinforce and solidify his withdrawn, isolated stance. Consequently, I suggested the following behavior plan in a meeting with his parents and teachers. Lisa, the teacher to whom Carlos's mother felt closest, agreed to be a "preferred provider" who would focus on Carlos when possible.

A Home- and School-Based Plan for Carlos

After we discussed my recommendations, I gave everyone a copy of the suggested plan, which is presented below.

1. Increase Carlos's sense of continuity between home and school.

- *Parents set positive expectations*, telling Carlos that they know he doesn't talk often at school but that they would like him to because it would be more fun for him. Parents say to him that they know he likes to talk at home and that they think he would like to talk at school.

- *Parents convey enthusiasm/acceptance of school*, so that Carlos feels he has their "permission" to have a good time there.

How to do this:

- Talk about school at home. This should be based on information from teachers rather than asking Carlos what he did at school.

- At drop-off, a brief but enthusiastic conversation should be held between Ana (or John, when he brings Carlos) and Lisa or another teacher. The content should involve something Carlos has done the day before at home. The tone should be warm, so that Carlos sees a good feeling between his parent and the teacher.

- At pickup a similar conversation should take place, in which the teacher describes some of the things Carlos did that day. What the teacher says should be informational rather than evaluative of what kind of day he's had. However, if Carlos has spoken more, become involved in a particular activity, or

played with another child, this should be pointed out with pleasure and enthusiasm. John or Ana should mirror the teacher's feeling.

- In the end-of-day conversation, the teacher should mention some activities that will be happening the next day. The following morning on the way to school, Ana or John can talk about this in order to help Carlos anticipate his school day.
- For consideration if work schedules permit: (a) Ana or John spends some time at school in the morning, looking at materials, asking Carlos about other kids, engaging him in conversation that elicits his knowledge of school; (b) Ana or John arrives 20 minutes before regular pickup time and spends some time playing with Carlos or watching him play with other kids (Note: This could be done two or three times a week at first, then decreased after a few weeks); (c) John or Ana go on some field trips with the group.
- *Peers.* Arrange opportunities for Carlos to play at home with children from his school. At school, teachers say to Carlos: "Your mom told me that Shelby came to your house to play and that you had fun together. You can have fun together here too."

2. Teachers address separation issue directly.

- When Carlos's mind seems to be elsewhere, consider that he may be thinking about and missing his parents. This can be addressed by saying: "Sometimes when kids are quiet, they're thinking about their mom and missing her. Let's do something together so you'll feel better."
- Let him keep a transitional object in his cubby. A family picture is good. If he appears lost, suggest he go and look at the picture. Look at it with him and talk about some specifics regarding his family.
- Suggest play involving separation themes with a teacher. Using two houses and dolls, play out directly leaving home, going to school, being picked up, and so on, with Carlos being encouraged to take control of the play.

3. Help Carlos speak and interact more with other kids at school.

- Teachers note and reinforce *each time* Carlos makes a request of a teacher or speaks to another child. Don't interrupt a conversation if one actually happens, but afterward offer positive and specific encouraging statements. For the first 2 weeks, try as much as humanly possible to verbally reinforce Carlos's speaking every time you see it. For example:
- "That was great, Carlos. You spoke to me and I knew just what you wanted!"
- "You had fun singing that song with Shelby."
- "You showed/told Shelby what you wanted, and she did it!"
- Teachers look for opportunities to interpret social overtures by other kids to Carlos.

- "Rosie's showing you a picture of a polar bear. She thought you'd like to see it. Friends like to show each other things."
- Without forcing, a teacher takes Carlos's hand and leads him over to a table where kids are drawing or working with puzzles. Ask him to sit down at the table, so he can see what they're doing. Then, if another kid offers him a marker, point out: "Kamali wants to share the markers with you. He wants you to color with him."
- When possible, teachers arrange pairing Carlos with another kid—for example, walking together on a field trip or going together on an errand with a teacher. Try to build upon natural or accidental pairings. For example, a teacher has been reading to Carlos and another child, then helps them transition into playing together.
- Parents express pleasure/happiness when they see Carlos interact with another child at school. For example: "Carlos, I'm so happy that you talked to Andrew. I want you to have friends at school, and talking is a good way to make friends."

Assumptions Underlying the Behavior Plan

The plan was informed by the following ideas:

1. If Carlos senses increased continuity between home and day care via positive interactions between teachers and parents, talking about day care activities at home, and vice versa, and having opportunities to see day care peers at home, he will begin to feel more comfortable interacting at day care.
2. If his mother can convey interest in his activities at day care, she will implicitly convey her permission for him to become more involved with caregivers and peers.
3. Frequent positive reinforcement for interacting or speaking at day care will support the development of Carlos's social abilities.
4. At day care, encouraging joint-peer attention (Carlos and other kids sharing the same experience) and explicitly interpreting other children's social cues for Carlos will also support the development of his social abilities.
5. Specificity and detail would help caregivers and parents understand and carry out the plan.

Follow-Up Note

This plan worked well, primarily because his parents and teachers invested in it. Within a month Carlos was speaking regularly to teachers and other children and was playing with a few other children regularly. At the time of the initial evaluation, I proceeded on the assumption that Carlos's difficulties

were based on shy temperament and identification with his mother's alienation from American culture. A few months later, Carlos's father contacted me and indicated that he and his wife had been having severe marital conflicts since returning from Panama. This suggested a more compelling explanation for Carlos's increased insecurity and separation anxiety. In spite of this deeper issue, the increased efforts of teachers and parents to help Carlos feel more comfortable with peers supported him in the tasks of social development in the fourth year of life. Their intervention was tailored to this goal and provided the encouragement and frequent reinforcement Carlos needed to find his voice. My primary role was to help devise an intervention plan carried out by providers and parents. For this presenting problem, an ecological approach was more effective than psychotherapy. Table 10.1 summarizes assessment issues for preschoolers.

INTERVENTION WITH PRESCHOOLERS: PLAY THERAPY

From a developmental perspective, the aims of therapy with a preschooler often include addressing troubling ideas and feelings, based on the child's cognitive limitations, and encouraging the child to move toward verbally mediated understanding of his experience. Here are some characteristic objectives in the treatment of preschoolers.

Help the Child Clear Up Misunderstandings

The preschooler's tendency to try to understand reality through fantasy can generate anxiety that leads to symptomatic behavior. For example, Angie, the child described in Chapter 9 who displaced her anger about her mother's pregnancy into defiant behavior toward her pregnant child care provider, had evidently come to feel that the new baby would take her mother away from her. In a brief parent–child treatment, I coached Angie's mother to talk with her directly about this worry and to reassure her that she would love her and do "mommy things" with her after the baby was born.

Clarify Overgeneralizations

Preschoolers tend to overgeneralize on the basis of their stressful experiences. While generalization and categorization are normal aspects of cognitive development, generalization of stressful events can disturb children's ability to assess reality accurately. As a result, children may become anxious in situations that have associational reminders of the stressful or traumatic situation, or even come to associate any anxiety-provoking situation with the traumatic situation. For example, it is common for young children who have witnessed violence to become hypervigilant and expect that violence could occur at any time, even in situations far removed from the original situation. Tisha, the

TABLE 10.1. Summary of Assessment Issues for Preschoolers

General considerations

- Play interviews are rich sources of information about the child's thinking, emotional concerns, and representation of experience.
- Assessment should include observations in settings outside the clinic, especially child care settings.

What to observe

- Quality of discourse and language: How easily can the child express herself? Can she create detailed narratives? Are vocabulary, grasp of language structures, and articulation appropriate for age?
- Quality of play: Is the child's imaginative play rich in narrative, or is it limited and repetitive? What themes and plots are expressed, and how do they reflect the child's experiences? Can the child play well with others?
- Social skills: Does the child have friends she plays with often? Can she appraise social situations with age-appropriate accuracy? Does she show an ability to work on resolving conflicts with other children? Does she have age-appropriate theory-of-mind skills?

Concerns/Red flags

- Generalization of insecure attachment: Children with histories of insecure attachment may not seek support from nonparental adults, instead adopting a mistrustful stance; alternatively, the insecure child may cling to or try to control caregivers, and may show ongoing, strong separation anxiety at a period in development when most children can cope well with separations from parents.
- The preschool child who has poor relationships with peers is at risk for poor peer relationships in middle childhood, when peers take on increasing importance. Children who are aggressive toward peers are often rejected and excluded in the preschool peer group.
- Children who are withdrawn (for reasons ranging from shy temperament, to depression, to a history of trauma) are also at risk for poor peer relationships.
- Impoverished language development: The preschooler with limited vocabulary and delayed understanding of language structures may (1) have poorer than average self-regulation because he cannot communicate his frustrations; (2) have poorer peer relationships because he cannot make himself understood; (3) be at risk for learning disabilities in reading and writing later in development.
- Play issues: Play that frequently crosses the boundary between fantasy-aggression and actual aggression or play that contains repetitive aggressive or fearful themes may reflect a history of trauma. Play that is impoverished and inhibited may reflect a history of neglect.
- Difficulties in attending and concentrating or impulsive behavior suggesting difficulties in self-regulation may reflect signs of ADHD, generalized ongoing difficulties in self-regulation, or heightened responses to stress that may be based on negative experiences, including trauma, abuse, and neglect.

child described in Chapter 9 who was very aggressive with other children at her child care center after witnessing domestic violence, needed explanations from her mother and teachers to understand that she was safe at the child care center and that her teachers would not allow the type of violence she had wit-

nessed to occur there. Her teachers told her that they knew what she had witnessed and that they would not allow grown-ups to hurt anyone at the center. These interventions validated Tisha's perceptions and feelings but identified her overgeneralization as invalid.

Help the Child Move to Verbally Mediated Understanding of Experience

Talking with a child about her experience by organizing it into verbal narratives that specify cause-and-effect relationships and distinguish between past and present allows her to gain a sense of control and cognitive competence. As a normal part of development, young children and parents coconstruct narratives about the children's experience. This process contributes to a child's capacity for self-regulation by increasing her ability to understand and evaluate experience (Haden, Haine, & Fivush, 1997). In child therapy, representing experience in play narratives and words similarly promotes regulation of affect and behavior (Slade, 1994). Verbalizing feelings allows the child to get some distance from strong impulses and affects so that she does not have to act on them immediately. Being able to substitute thinking for acting promotes a sense of mastery and self-control. As the child gains some verbally mediated mastery over anxiety-producing feelings and impulses or stressful past situations, she is likely to become less symptomatic. This objective is particularly important in the therapy of children who have difficulty controlling impulses. Since preschoolers are not able to represent all their feelings verbally, the therapist needs to encourage the process of verbalization and verbally mediated thinking by putting into words what the child symbolizes in play. This accomplishes several things:

- The child feels she is not alone with her problems; as the therapist puts thoughts and feelings into words, she feels that someone else understands.
- Her experience is given narrative meaning as autobiographical memory, enabling her to have a clearer sense of reality and of the distinctions between past and present.
- She gains a means of thinking about her experience and gradually can begin to talk about it herself.
- Her experiences and affects are linked together in a way that makes sense.

USING PLAY IN THE TREATMENT OF PRESCHOOLERS

Since preschoolers readily utilize pretend play to represent experience, play can be the clinician's entry point for a dialogue—involving both action and words—about the child's difficulties. This displacement of real experiences

into play creates a safe vehicle for mastering stress or confusion. In part, play provides a means of dramatizing one's concerns beyond mere words; in another way, play provides protection: Play is about fantasy characters, not about the self. Practitioners should pay attention to the story and themes represented in preschoolers' play. It is useful to assume that the child's play is telling a story that reflects his concerns.

Preschool children understand the distinction between real and pretend. They are also able to step out of play temporarily, much like the movie director who yells "Cut!" and tells the actors what she wants them to do and then shouts "Action!" to resume the drama. Therapists can make use of the preschooler's ability to distinguish between the play frame and the reality frame. The therapist can stop the play briefly at times and comment on its content and then resume play. Even though a child may not welcome such breaks in the play, they feel normal to her.

Most preschool children, once they have begun to feel some trust in a therapist, prefer that the therapist play with them, as opposed to passively observing their play. A smaller number of children prefer that the therapist stay outside the play, and this must be respected. During the preschool period, players take roles and act them out, which means a preschool child will expect the therapist to become an actor in his play scenario. The therapist must be willing to become a player. As a participant-observer in the play, the therapist can learn how the child constructs his experience and is in a unique position to make interventions, both within the flow of play and by stepping out of the play to comment on it (Chethik, 2000).

The case that follows illustrates the use of play therapy with a 4-year-old girl whose development was impacted by medical treatment for a cancerous brain tumor. We look at the preschooler's ability to use play to communicate concerns she is not yet able to express in words, as well as the therapeutic potential of play interpretation. Before presenting the case, I discuss the problem of developmental interference, with particular reference to the interaction between extended medical treatment and the preschooler's developmental tasks.

MEDICAL TREATMENT AS A DEVELOPMENTAL INTERFERENCE

Tremendous advances in treatment for childhood cancer in the past 30 years have increased the survival rate to approximately 80% (U.S. Cancer Statistics Working Group, 2004). But successful medical treatment may result in psychosocial and developmental side effects. The prolonged and invasive treatment common to cancer therapy protocols interferes with future development in some child cancer survivors. Children treated during the toddler and preschool years are particularly vulnerable to developmental interference (Davies & Webb, 2009; Rennick et al., 2002).

Cancer treatment typically involves the onslaught of a number of stressors, including hospitalization, anxiety about dying, pain from spinal taps, bone marrow aspirations and other procedures, nausea and weakness as side effects of chemotherapy, bodily changes such as hair loss, loss of familiar routines, disruption of friendships, and in some cases separation from parents. Some cancers have more severe short- and long-term developmental effects. In children with brain tumors, with those under age 7 being most at risk, cranial radiation therapy and methotrexate chemotherapy disrupt the growth of white matter that forms myelin sheaths insulating brain axons. The functioning of the circuits in the brain becomes less efficient, resulting in neurocognitive effects, including IQ decreases in the range of 15–25 points, slower rates of learning, and cognitive impairments in attention, memory, and processing speed (Moore, 2005).

Rutter (1981) noted that the capacity of preschool children to cope with future stresses was reduced by the stress of multiple hospitalizations. Coping styles developed in response to hospitalizations tended to persist even if they were not adaptive from the perspective of the tasks of future development. Many preschoolers develop a precocious maturity, becoming unexpectedly compliant with treatment; however, this precocity may become generalized and show up later as inhibitions and behavioral rigidities that interfere with development (Phipps, Steele, Hall, & Lee, 2001). Intrusive imagery of cancer treatment and fears of dying may surface when suppression of affect no longer feels necessary for emotional survival (Kazak et al., 2006).

Compared to the school-age child, the preschooler's internal mechanisms for coping with stress are not yet well developed. The more sophisticated defenses characteristic of the school-age child—repression, rationalization, denial in fantasy—are not yet in place. Lacking adequate coping strategies, the preschooler is more likely to become overwhelmed during stressful procedures and may either shut down emotionally or lose control and dissolve into tantrums (Chen, Zeltzer, Craske, & Katz, 2000). Prolonged invasive medical treatment is likely to interfere with a number of developmental tasks of the preschool child, including the development of an autonomous self, beginning peer relationships, elaboration of play and fantasy, and control of one's body in terms of regulation of body functions, physical activity, and mobility. At a time when these developmental issues are in ascendancy and therefore subject to disturbance, cancer treatment and hospitalization cause the preschooler to experience a loss of autonomy and self-control, increased dependency, isolation from peers, restrictions on freedom to play, restrictions on physical activity and mobility, and a sense of physical vulnerability.

During the preschool period the ability to play imaginatively is a major adaptive mechanism for the mastery of stress as well as the primary pathway for exploration that facilitates learning and socioemotional development. Play supports the development of autonomy and initiative. Cancer treatment disrupts the child's ability to play actively and strenuously, and has inhibiting effects on her ability to fantasize (Erikson & Steiner, 2001).

Such inhibited behavior can be understood from the perspective of attachment. Although still reliant on the attachment relationship when under stress, the preschool child is moving toward a sense of the self as autonomous, self-reliant, and purposeful. This movement is supported by an internalized secure base of positive working models of attachment. When a preschool child experiences prolonged stress due to illness and medical treatment and must revert to dependency on parents and other caregivers, her developmental progression toward autonomy may be compromised. An inhibited child does not compel attention as dramatically as a child whose behavior is impulsive or out of control. However, serious inhibitions during the preschool years may have a negative impact on the child's ability to interact with the world and thus foreclose many normal developmental opportunities, including openness to learning in middle childhood.

The likelihood of developmental interference is increased by the preschooler's cognitive characteristics, including egocentrism and prelogical magical thinking, which does not distinguish clearly between intention and result or between cause and effect, especially when stressors are operating. Consequently, a preschooler may develop distorted notions about the causes of her illness, including mistaken associations between the onset of the illness and coincidental external events, and is likely to regard invasive and painful medical procedures either as sadistic abuse or as punishment for misdeeds. Further, the preschooler has limited ability to understand abstract explanations of medical issues that she may overhear in the hospital and is prone to impose idiosyncratic constructions on them (Bergmann & Freud, 1965).

PLAY THERAPY WITH A PRESCHOOL CHILD: A CASE EXAMPLE

The case of Katy is an example of a developmental arrest caused by a preschooler's reactions to a serious illness following an early history of excellent development in the context of a stable and loving family (Davies, 1992). Although the cancer treatment was sometimes traumatic and at other times quite stressful for this 3- to 4-year-old girl, her previous excellent developmental progress and remarkably supportive parents combined to protect her from more severe effects of the treatment. Katy was buffered by other protective factors, including middle-class status, her parents' high levels of education, and family and friends who supported the family in many ways, including providing care for her younger brother. Nevertheless, she did show evidence, at age 4, of developmental arrest in the social and affective areas.

Medical History

Up to the onset of her medical symptoms at age 3, Katy was a vivacious, outgoing child who played vigorously and had a good sense of humor. Near

her third birthday, her parents noticed that Katy seemed to become moody and that she "stopped playing." Over the next 3 months she became more and more somber and less and less active. She complained of feeling weak and began to have headaches. However, her pediatrician could not find any evidence of illness. When she refused to get out of bed because her head hurt, her parents took her to the emergency room, where she was diagnosed with a malignant brain tumor.

The tumor was removed in an 8-hour surgery. Katy was in considerable pain for 10 days following surgery. Over the next 7 weeks of hospitalization she had several minor surgeries, including the placement of a shunt to drain fluid from the surgical site, two repairs of the incision, and the placement of a Broviac catheter in her chest wall. (A Broviac is a catheter tube that is inserted into the vena cava, the large vein near the heart. It is used for the administration of chemotherapy. The toxic cancer medications would have severely damaged Katy's veins if dripped into her arms; by using the vena cava, where the volume of blood is much higher than in the arm veins, the medications were diluted more quickly and did not cause vascular damage.) All together, she underwent general anesthesia six times. One repair of the incision was done without anesthesia and seems to have been traumatic: Katy became hysterical and had to be held down, and the doctor yelled at her to stop crying as she restitched the wound. Katy also received cranial radiation, which caused her to lose her hair.

Over the next 15 months, Katy was hospitalized 10 times for 2-day periods of chemotherapy. As she realized that the chemotherapy made her feel terribly ill, she began to resist it and had to be coaxed by her parents. She told her parents that she thought the chemotherapy might make her die. Most of the time, however, she seemed to submit passively. There were also many other invasive procedures, ranging from extremely uncomfortable and at times painful spinal taps to needle pokes for IV (intravenous) lines and blood draws. Her parents reported that Katy was forced to do things in the hospital that she didn't want to do—to have IV needles changed, to be awakened at night to go to the bathroom, and in general to adapt to the hospital routines. Another consequence of her illness was that she had to be kept away from other children when she was out of the hospital. The chemotherapy had compromised her immune system so that an ordinarily mild illness such as measles would be life-threatening to Katy.

Her parents and the medical staff, however, had explained what was happening to her, and her parents had been remarkably supportive and consistent with her in spite of the tremendous stress her illness imposed on them. One of her parents had been with her at all times when she was hospitalized. Katy, for her part, had been cooperative or stoic in response to all but the most surprising or painful procedures. By the standard of overt distress, which is commonly seen as a measure of coping (Phipps et al., 2001), Katy seemed to have tolerated her medical experiences well. She had used an array of coping mechanisms, including the support of her parents and the medical staff, complying with medical procedures, and defense strategies such as denial and the blocking of affects.

Assessment Impressions

I began seeing Katy when she was 4 years and 8 months old. At that point her cancer treatment was completed, and medically she was doing well. Her parents were aware that her cancer could recur and also that she would be at risk for developing leukemia later on. They referred her because she had become such a serious, quiet, inhibited child, quite different from the vivacious 2-year-old they remembered. They were concerned that she had reactions to her hospitalizations and fears of death that she could not talk about. She often hinted that she remembered stressful medical procedures but avoided her parents' attempts to talk with her about them. Like other young children who have experienced stressful medical interventions, she apparently attempted to cope with conscious negative memories by suppressing them (Chen et al., 2000). She was extremely cautious physically and no longer threw herself into play. She refused to do "risky" play like swinging, jumping, or climbing. Katy told me that she thought she'd gotten cancer because she fell off the jungle gym when she was 3. She was enrolled in part-time day care but was standoffish with other children and played mostly by herself, probably because she had missed out on learning to play with other children over the previous year and a half, and also because she was still afraid of catching a disease from another child. She also seemed arrested in her ability to play. At home, at day care, and in the early treatment sessions, her play had a constrained, tentative, and obsessional quality, and it lacked the rich fantasy themes typical of a 4-year-old. These were indicators that her experience with cancer treatment was interfering with her development. My impression on meeting Katy, however, was that she had a full range of affect and fantasy available to her but that she kept them under wraps. She was nearly silent in sessions. Nevertheless, I felt engaged with her and believed that beneath her inhibitions and affective constriction, she might be imaginative and articulate.

A Developmental Treatment Approach

The treatment goals were as follows:

- To help her recover the ability to play. This would open up for her an age-appropriate pathway for developmental progress and the mastery of stress.
- To help her gain some mastery over the traumatic aspects of cancer treatment by playing out, in an active way, those experiences to which she had previously had to submit passively. An essential part of this goal would be to give Katy a chance to communicate a range of affects—

especially anger and negativism—that she had suppressed during her medical treatment.
- To help her differentiate her experience with cancer from her present experience. This would involve helping her see the cancer treatment as a past experience, not a lens through which to view the present.

Katy's symptoms did not meet the criteria for a diagnosis of posttraumatic stress disorder. However, I suspected that her cancer treatment had been traumatizing and that her defensive avoidance of articulating any memories and feelings about her treatment might mask other symptoms. Traumatization during medical treatment is associated with poorer long-term adaptation for child cancer survivors (Erikson & Steiner, 2000). Further, Katy's parents' description of her now globally inhibited behavior raised the possibility that her reactions to cancer treatment had interfered significantly with the pre-cancer trajectory of her development and might crystallize into more serious difficulties with anxiety and depression when she entered middle childhood (Pynoos, Steinberg, & Piacentini, 1999).

My therapeutic approach was a focal psychotherapy to help a child master a developmental interference (Chethik, 2000). The treatment modality was individual play therapy and parent guidance. (The parent work is not described because it was minimal. The case is atypical in this respect. Ordinarily, parents also need a chance to work through the traumatic impact of their child's life-threatening illness. Katy's parents had done a remarkable job in helping Katy cope with her illness and in coping with it themselves. From the beginning of her illness, they had demonstrated resiliency by actively evaluating treatment options and forging an alliance with the medical team. They had already made extensive use of outside supports, including a family intervention during Katy's illness.)

The play of preschoolers in the therapeutic situation is best seen as their representation of significant aspects of their experience and as a commentary on what their experience has meant to them. Starting from this assumption, the practitioner attempts to understand the meaning of the play and then to provide interpretive commentary that helps children take a new perspective on their experience, with the aim of reducing developmental interferences. At the outset, the therapist makes statements about the problem for which the child has been referred. I told Katy, "Your mom and dad wanted you to see me because they think you might have some worries and scary feelings about cancer and the hospital. My job is to help girls with their worries, and your mom and dad thought I might be able to help you." If this problem statement is salient for the child, play representing the child's experience of the problem begins to emerge, often in the first session. For Katy, this took the form of her laying out 20 or so rectangular blocks and then placing small dolls lying down on each of them. I watched her and said, "This is too big to be a family; there are so many beds, I wonder if it's a hospital." Katy looked me in the eye and said, "Yes." Through this process the play becomes focused, organized,

and meaningful. The child preconsciously understands that the therapist sees play as a representation of experience and begins to use it to express what has been difficult for her. In order to help focus the treatment, I had a toy doctor's kit and some medical paraphernalia—surgeon's mask and cap, IV tubing and tape, and the like—available for Katy's use. I never directed her to play with these materials but pointed out that she could use them to show me her worries, just as she could use the more standard child therapy toys.

Course of Treatment

Katy's early play was inhibited and constrained. She chose to draw and play board games, speaking little, and avoided developing any fantasies in her play. I was content to give Katy some time to acclimate to the therapeutic situation. Feeling forced and controlled had been inevitable features of her medical treatment. I felt that it was particularly important that Katy not feel forced in this relationship. I saw the early sessions as an opportunity to establish a friendly and supportive relationship with Katy. Her drawings were mostly of rainbows and hearts. As she drew, we spoke about the bright colors she liked to use, and I commented that she seemed interested in practicing getting her rainbows just right. We also played Candyland, a simple board game appropriate for preschoolers, since it is based on chance and does not require the use of strategy, which is generally beyond the cognitive level of preschoolers. Katy took pleasure in winning the game, though she seemed to be working to keep her affects in check. This was consistent with the affective restraint that had been an adaptive coping device when she was in the hospital. My main intervention during these early sessions was to mirror her excitement and pleasure in a slightly exaggerated manner in order to model the possibility of a wider range of affect.

After Katy became more comfortable showing pleasurable feelings, I began to model negatively toned feelings. For example, in the third session, I offered her Play-Doh—a good material for eliciting affects of anger and frustration. Children like to pound on it and work it vigorously. As Katy pounded on Play-Doh with her fist, small breakthroughs of affect began to occur. When a piece dropped on the floor, and Katy looked displeased, I amplified her facial affect by saying, "That stupid Play-Doh! It fell on the floor!" Katy was pleased and repeatedly dropped the Play-Doh, while I continued to express irritation. My aim was to demonstrate to Katy that negative affects could also be safely expressed within the therapeutic situation.

The first significant play commentary Katy made on her hospital experience appeared in the third session, after we had played with the Play-Doh. In the course of playing catch, Katy began hitting me on the head repeatedly with a foam ball. Given that Katy had had many hurtful things done to her head, I did not think this was random or merely diffusely aggressive behavior. I told her that of course it didn't hurt to be hit with the soft foam ball but that I would pretend to be hurt. I complained a lot about being hurt, and she con-

tinued to hit me with the ball with a grim expression on her face. I also pretended to be mad, which she thought very funny. When she took up this play in the next session, I focused it around her medical treatment. I told her that I would pretend to be a kid at the doctor's office who was getting hurt by what the doctor was doing. As she hit me with the ball, I said, "Doctor, that hurts. I don't like you to hurt me. I'm getting mad at you for hurting me." After a bit I stepped out of the play and said, "I'm showing how kids get very angry when the doctor hurts them." At this point, Katy got a girl doll, took off its clothes, and began taping an IV tube to its chest. I spoke for the doll and asked if what the doctor was doing would hurt. Katy, as the doctor, gave a small, enigmatic smile and mumbled incomprehensibly. (This, it appeared, was her representation of the doctor—someone who did hurtful things, all the while smiling and mumbling, but not being responsive to her feelings or questions.)

Following this direct representation of medical procedures, Katy's play became more symbolic but still affectively salient. She developed a game of throwing markers on the floor and telling me, "Pick 'em up!" This was repeated many times. I asked her how I was supposed to feel about having to pick up the markers all the time, and she said, "You don't like it." I echoed this feeling each time she threw them on the floor. I commented that she was helping me understand how it felt to be forced to do something you don't want to do. I said her mom had told me that she'd been forced to do a lot of things when she was in the hospital. Over the next few sessions, she elaborated the game. We would both pretend to go to sleep in our chairs. While I remained asleep, she would get up and throw markers and crayons all over the floor. Then she would turn over the play chairs with a big thump, which would be my signal to wake up and pick everything up. Within the play, I said, "I hate to be woken up. I don't like to be forced to pick up all this stuff." Katy said, "You have to." I commented that a kid in the hospital wouldn't like it when the nurse woke her up and forced her to have a shot or made her get up and go to the bathroom.

This hospital play scenario was fully elaborated in a session 2 months into the treatment. As usual, Katy threw markers on the floor and turned the chairs over. While I was sleepily picking things up, I complained that I hated being awakened in the middle of the night and that I wanted to be home in my own bed. I didn't want to be in this stupid hospital. She said, "Now you have to get up and pee." I said, "I'm not going to, and I'm not going to take my medicine either!" Katy looked very grim and said, "You can't say that." I said, "I don't care! I hate this hospital!" She hit me on the shoulder, looking very stern. I said, "Why am I in this hospital?" She said, "You have cancer." I said, "I hate cancer and I hate chemotherapy, because it makes me feel so awful. I'm not having any more chemotherapy or radiation!" She said, "You have to have surgery." I said, "No!" She hit me again and said, "You already had your surgery." I said, "Yes, and it hurt so much after I woke up." She said, "Now you're going to get a Broviac." I said, "What's a Broviac?" She said, "It's just a little tube that goes into your chest." I said, "I'm not getting any Broviac!" She hit me again and said, "Yes you are, and you're going to get an IV and a shot too." I made several comments at the end of this hour—that she had helped me know how it felt to be in the hospital and shown me many of the things that she hadn't liked, that she had helped me feel how scary it could be for a kid, how mad a kid could get about having all kinds of painful and scary things done to her, how a kid hated to be forced, and how confusing it felt when doctors, who were supposed to be helping, sometimes did things that hurt a kid.

In the sessions immediately following, Katy began to take the role of the patient. For example, she took the cushions off my office chairs and lay down on them. She instructed me to get some puppets who should wake her up. The puppets told her it was time to wake up, and she woke up with a vengeful look and began pummeling the puppets until they were knocked off my hands and flung across the room. When I had the puppets say, "Wake up—it's time to take your temperature and go to the bathroom," Katy bit the puppets and threw them against the wall. Then she made a bed out of blocks and put a girl figure on the bed. She built up the sides of the bed and placed other figures there, standing over the girl. I commented that the girl looked as though she was in the hospital, and Katy confirmed this. Then, in a representation of the pain she experienced in the hospital, the figures standing over the girl pushed blocks on top of her. I said, "I think you're remembering about doctors and nurses looking down at you. What happened to the girl showed me how confusing it could be to have doctors hurt you when they were supposed to be taking care of you."

Over the next several sessions, Katy's play shifted from hospital themes to themes of protection and safety. She crawled under a chair and refused to talk to me. She brought her hand out from under the chair and motioned that I was to chase it with my hand. My hand chased hers but was never able to catch it. Then she began grabbing my intruding hand and throwing it out from under the chair, and looked very pleased with her ability to repulse me. I commented that it looked like she was in a very safe spot under the chair and that it must feel good to be in a safe spot. She probably felt that there weren't any safe spots in the hospital. She couldn't get away from having people do things that scared her and hurt her, and she must have wished then for a safe spot. I said, "In our game, you're the one in control. When my hand comes in, yours is too fast and always gets away. Or else your hand is too strong and throws mine out. I bet you wished that you could have thrown those doctors and nurses away from your bed in the hospital."

By now the therapy was in its third month, and Katy's parents were reporting that she was much more social at school, that she was less inhibited, and that she was expressing negative or angry feelings much more openly. She was becoming very bossy to her brother and had some angry outbursts toward her mother. Her mother had been taken aback, because this was so unlike Katy. Her parents were pleased, however, because Katy was expressing a wider range of feelings.

The last month and a half of treatment focused on themes of mastery and putting her illness in perspective. I have selected 3 hours during this final phase that seem to summarize not only these issues but also to underscore the strong progressive developmental forces in Katy, which were becoming more available to her.

In the first of these hours, Katy pushed a chair over to the window, got up on it, and looked out at a nearby park. She pointed out a playground. Then she began jumping off the chair. At first she held my hand each time, then began jumping off on her own. I said, "This reminds me of how you used to be afraid of jumping or falling, because you had the mix-up that falling off the jungle gym made you get cancer. Now, I see that you can jump without being too scared." Katy did not respond verbally but went into the closet and pulled the door shut. She pretended to be a kitten locked in the closet, and it was my job to let her out. Several times when I opened the door; she had a very somber expression, and I commented that the kitty was looking sad. About the fifth time I opened the door, she had a very happy expression and pranced around the room, flapping her arms, pretending to fly. This scenario was repeated about four times. Then, when I opened the door, her expression was threatening and she poked at me with a coat hanger. Next she huddled up in the corner, hiding her head. Finally, the flying girl came out again. I commented that her happy play reminded me about how she felt before she got cancer. But then she got sick and felt awful and scared and sad and just wanted to huddle up and hide from people who might hurt her. Sometimes she was also very angry but was afraid to let people know she was mad. I said, "Now that you're feeling much better, it seems like you can be a happy, flying girl again who can do lots of things. Maybe you're not so worried now about getting sick again."

A few days before the second significant hour in the final phase, Katy had had her 6-month computerized tomography (CT) scan, and it had been normal. Katy spent much of the hour showing me tricks she could do. She jumped off the chair in a number of different ways: first off the seat, then higher from the arm, then backward off the seat. She did somersaults and pretended to be a ballet dancer. I admired all the things she could do and complimented her abilities and her initiative. She also spent a good deal of time carefully building a house out of Lincoln Logs. I was pleased to see this kind of play because it is a normal type of skill-building play for a 5-year-old. A shift from play referring to trauma to such developmentally appropriate and conflict-free play is one of the signs that a child is becoming free from preoccupation with trauma-based anxiety.

At the beginning of the third significant hour, which occurred a few sessions before treatment was concluded, I began by saying, "Your mom told me that your CT scan showed that you don't have any more cancer." Katy said, "Yes," and immediately became the kitty. She had me pull the two office chairs together to make a bed. The kitty climbed on to the bed, yawned, stretched luxuriously, and went to sleep. She smiled in her sleep, and I commented that the kitty looked like she was having nice dreams. Then the kitty climbed down and frolicked around on the floor. I said, "The kitty looks like she's feeling very good. I bet she's happy now because she doesn't have to go to the vet all the time or stay in the kitty hospital." The kitty answered by rolling around on the floor, stretching, and going to sleep. Then kitty woke up, looked very alert, and began bringing me things in her teeth: a plastic dinosaur, a little plastic table, a piece of string. I said, "The kitty's very good at picking things up with her teeth." Then I decided to reintroduce the medical theme into the play, saying, "I don't know if you can carry that big doctor's kit in your teeth—it might be too heavy." Katy grinned at this challenge and picked it up in her teeth and carried it over to me. Then she opened the kit and immediately took on an angry expression. She dumped everything out and scattered it across the floor. I said, "The kitty doesn't like all that doctor's stuff. Maybe it reminds her of the vets and the kitty hospital." She took a surgeon's cap and mask and stuffed them in a drawer and slammed it shut. I said, "The kitty hates all that doctor's stuff. She doesn't even want to see it." Then she initiated a game of chasing a ball and bringing it back to me. Once, while chasing the ball, she came across the doctor's kit and flung it across the room. I said, "The kitty doesn't like that doctor stuff because it reminds her of when she was in the hospital and people did things that hurt her. But it's very good that the kitty is healthy now because it means she won't have to stay in the hospital. She'll still have to go to the doctor for checkups and tests, but that won't be like staying in the hospital." Katy handed me a toy syringe and motioned for me to give her a shot. I did and said, "That shot was to keep you from getting sick. It didn't seem to hurt too much." She handed me the stethoscope, and I listened to her heart and said, "It sounds very good." The kitty yawned and stretched contentedly. I summarized this play by saying, "I know that you're just like the kitty—you're very happy to be feeling good again."

During the remaining few hours before termination, the medical themes were absent from Katy's play. However, more generalized issues of anxiety about being hurt and feeling safe were brought up, particularly in response to the pressure of termination. For example, Katy spent a lot of time standing on the arm of the chair looking out the window, and she wanted me to be close to her. She repeatedly pretended to lose her balance and had to grab onto me to keep from falling. I said, "This reminds me of how you used to be afraid of falling because you thought that had caused your cancer. But that's not true. Falling down didn't cause it." I also said, "Since you've been seeing me, you've been feeling lots better, lots happier, and you can do more fun things, like play games with other kids and even climb to the top of the jungle gym. Maybe you're worried that when you stop seeing me, you'll start falling again. But that's not going to happen because you've been practicing, and you've gotten very good at climbing and jumping and at keeping yourself

safe. And now you don't need to get extra worried about falls and bumps because you know that even though they might hurt, they're not going to make you sick."

Discussion

At the end of this 5-month-long therapy Katy was far more expressive, showed a fuller range of affects, was much less anxious about her physical safety, was more active physically, and was more social. The intervention helped her give up her internal preoccupation with and anxiety about her medical experiences. Other factors besides therapy contributed to her resumption of an apparently normal developmental trajectory. These included her relief that she was feeling better physically, her opportunity in the day care center to become a "regular kid" interacting with other kids, and her parents' ability to support her assertiveness and expressiveness.

Play therapy enabled Katy to represent in play her subjective account of cancer treatment. Her play presented a story of a young child who felt frightened, helpless, and rageful, was confused by the pain of treatment that was supposed to help, and viewed herself as a victim of sadism and perhaps as deserving punishment for being bad. This affectively rich play representation was very different from her self-presentation while hospitalized, when for the most part she was subdued, compliant, and cooperative. Out of necessity, Katy had developed the ability to modulate and contain anxious reactions to all but the most painful or frightening procedures. Her precocious defenses and her ability to accept the support of her empathic and competent parents made it appear that she was coping well with her difficult medical treatment. However, as the story of her play suggests, it is important to distinguish between immediate coping and actual mastery.

Katy's play in therapy suggested that her coping capacity represented a self-protective process developed in a series of psychic emergencies, not psychological mastery of the experiences. After her medical treatment ended, the need to understand, master, and integrate her experience with cancer still remained. Paradoxically, her defenses had become organized around the need to suppress activity and affect; consequently, the normal means a preschooler uses to master and understand experience—play and fantasy—had become inhibited and were less available to Katy as vehicles for mastery. For this reason, *restoring the ability to play became an essential goal of the early stage of therapy.*

Katy's continuing reliance on the emergency-based defenses was having more pervasive effects on her development because she tended to overgeneralize them to nonemergency situations. The inhibitive strategies she developed during hospitalizations—compliance, overcontrol of affects, emotional withdrawal—became maladaptive when applied to normal tasks of preschool development, such as entering into peer relations and developing the capacity for initiative through imagination and physical activity.

By abstracting the main trends of the therapy, we can see how Katy gradually mastered these developmental interferences. At first Katy was inhibited in affect, fantasy, and activity level. After I indicated interest in her hospital experiences and encouraged the expression of affect, Katy progressively found ways to represent the negative feelings associated with cancer treatment. In the hospital play, Katy first attempted mastery through role reversal, putting me in the position of the hurt, frightened, angry child. Such role reversal is typical of preschoolers' tendency to represent anxious or traumatic experiences in compensatory ways. They try to deny and master real-life experiences of anxiety and helplessness by taking the roles of powerful, magical figures. By taking the role of the sick child, I had the opportunity to put Katy's unspoken story into words and to empathize with her experience. Essentially, Katy "taught" me how it felt to be helpless, scared, and impotently angry, and I responded by acting out and articulating those feelings in order to convey understanding of what she had been through. Once a play dialogue had been built up, with Katy in the powerful role and myself taking the weak role, I began to conceptualize her experience of medical treatment, define its limits, and differentiate it from present reality.

An important shift occurred when Katy gave up the medical play and established her "safe spot" under the chair. By controlling and repelling my play intrusions into her safe spot, Katy was mastering the repeated intrusions during her hospitalizations. I emphasized her ability to gain control. During the last phase of treatment two themes coexisted. One was oriented to the present and involved testing her physical abilities by jumping off the chair and doing somersaults. I acknowledged Katy's physical competence and used her physical activity as an opportunity to contradict her earlier belief that physical daring had been the cause of her cancer. Occurring in the context of therapy, Katy's physical activity represented her struggle to master fears of body damage. (During this period, her parents reported that she had resumed climbing on the jungle gym and was swinging again.) The second theme was play that "summarized" her experience with cancer and placed it in the context of her life. This was expressed through the kitty character, who seemed to go through cycles of intense anxiety and anger followed by relief and contentment. I interpreted this play to help her construct a view of her illness as a painful and frightening past experience that she would remember but that was separate from her current life.

As she was able to represent the story of her cancer treatment and have it confirmed and then interpretively differentiated from her current experience by a therapist to whom she had become attached, Katy gradually gained a significant degree of mastery over a series of extremely stressful experiences and resumed an adaptive developmental trajectory. The preschool child—because of her egocentric perspective, limited internalized coping mechanisms, and limited abilities in understanding and communicating verbally—may especially benefit from play interventions that help promote mastery of developmental interferences.

OBSERVATION EXERCISE

Spend 1 hour or more observing in a preschool or child care center. Focus on the following:

1. *Dramatic play.* Choose a group of children who are playing together. What are the themes and plots of the play? What roles do children choose or assign one another? Is the play gender-segregated or not? How do the children deal with disruptions of the play scenario caused by conflicts over whose fantasy will prevail? What reflections of the mass media do you see in the play?
2. *Peer relationships.* Choose two or three children who are playing together, either in dramatic play, building play, or other activities. Can you discern elements of friendship in the way they relate to one another? How do they resolve conflicts that arise? To what extent are other children allowed to enter or excluded from the play activity?
3. *Relationships with adults.* How much do the children interact with their teachers versus other children? Do you see attachment-seeking behavior? How do children cope with separation when their parents drop them off at the center? Do you see different styles of relating to teachers—such as friendly interaction, clinging, or withdrawal?
4. *Self-control.* Observe for potentially stressful situations—separation from parents, conflict with another child, having to wait to get the teacher's attention, and the like. What strategies for self-regulation do you observe? Do you see instances of aggression? What seems to have precipitated aggressive behavior? Do you see instances of prosocial behavior?

CHAPTER 11

Middle Childhood Development

The school-age child seems calmer, somewhat more serious, and less spontaneous than the preschooler. The preschooler handles the need to learn about the "real world" by assimilating reality into fantasies driven by her wishes and needs. In middle childhood, extending from age 6 to the onset of puberty between 10 and 12, the child gradually comes to see the world as a place with its own laws and customs, about which she must learn and into which she must assimilate herself. The child shifts from seeing herself as at the center of the world to realizing that the world is complex and that she must find her place in it.

While imagination and play remain important to the school-age child, he increasingly establishes his sense of self through a long apprenticeship of gaining skills. This theme is most clearly symbolized by the progressively more complex skills learned in school, but the themes of "learning how to" and "getting good at" increasingly inform the child's efforts in other activities, such as sports and hobbies. School-age children learn that success is based on practice, which helps explain their intensity and persistence as they work on building skills.

> A 10-year-old neighbor boy was shooting baskets in my driveway, over and over, when it began to rain. During a 10-minute period, it rained harder and harder, but he still kept shooting. My wife came home and said, "Hey, Liam, don't you know it's raining?" He said, "I've been through this before. All I have to do is keep focused."

This boy's behavior, although funny because he was standing out in the rain, illustrates many of the capacities of school-age children: sustained concentration, belief in practice, and keeping a purpose in mind in spite of distractions.

Middle childhood, also referred to as the "latency" period in psychoanalytic theory, is characterized by the child's capacity to maintain states of self-