Play and the Abused Child: Implications for Acute Pediatric Care

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Child maltreatment is a major pediatric health care concern. A large number of children will be admitted to inpatient pediatric settings for treatment of injuries that have resulted from child abuse and/or neglect. This article focuses on the role of play during the abused child's acute inpatient admission. Sensitive crisis management and careful assessment and treatment of the child through play are significant contributions to the comprehensive care of such children.

The maltreatment of children is a major pediatric health care concern in the United States (National Center on Child Abuse and Neglect, 1981). A large number of children who may require treatment of serious, nonaccidental injuries and/or respite from an abusive or potentially dangerous environment while child-protective services investigate the home are frequently admitted to acute care pediatric inpatient settings. This article will discuss the role of play in the comprehensive care of inpatient abused and/or severely neglected children. Comprehensive care includes crisis management and assessment of abused children by the health care team.

REVIEW OF THE LITERATURE

Literature documenting chronic social, psychiatric, cognitive, and neurodevelopmental sequelae of childhood abuse and/or neglect has expanded widely. Development is distorted and impaired. Poor self-esteem, lack of joy, pseudoadult behavior, and disturbed social relationships characterize many of these children (Kinard, 1982; Martin & Beezeley, 1976). Studies of seriously depressed or suicidal preschoolers have stressed the major role of parental abuse and/or neglect in the lives of these children (Kashani & Carlson, 1987; Kazdin, Moser, Colbus, & Bell, 1985; Rosenthal & Rosenthal, 1984). Kempe and Kempe (1978) describe the "frozen watchfulness" of abused children who expect punishment, are unable to play or explore, move from one toy to another in a haphazard, impulsive manner, and make little use of spontaneous language to promote relationships. Both abused and neglected children are at unusually high risk for neurodevelopmental and language delays. (Allen & Oliver, 1982; Green, Voeller, Gaines, & Kubie, 1981; Martin, 1981).

In addition, current studies, focusing on the consequences of different patterns of abuse as well as on the role of "protective factors," are indicating a greater complexity in the relationship between childhood maltreatment and development. For example, the age of the victim at the first incidence of maltreatment, the child's perception of the maltreatment, and the overall quality of family functioning are variables that warrant consideration (Augoustinos, 1987; Lamphear, 1986).

Despite striking, long-term developmental problems facing abused children, treatment has focused on the parents and their problems. This approach has been based on the belief that, by stopping active abuse, the developmental problems of these children would be alleviated. However, several authors (Mann & McDermott, 1983) regard direct treatment of the child as crucial. Cohn (1979) found only 3 of 11 programs that provided direct psychological treatment to a relatively small number of children. Improvement in several child behaviors and problems has been documented in children who

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received direct therapeutic intervention such as therapeutic day care, play therapy, individual and group therapy, residential care, and crisis nursery care (Beezeley, Martin, & Kempe, 1976, Cohn, 1979).

However, systematic guidelines for the treatment of maltreated children do not exist (Mann & McDermott, 1983; Mrazek & Mrazek, 1985). Some authors, such as Jernberg (1983), caution against confrontational techniques, especially during the acute phase. A top mental health priority is the development of research and demonstration treatment agendas to determine how best to help the child (Cohn, 1979; Fantuzzo & Twentyman, 1986; Frazier & Levine, 1983; Jones, 1986; Mann & McDermott, 1983).

Frazier and Levine (1983) have stressed the needs and behaviors of very young abused children (aged 0 through 4 years), the most frequent victims of abuse. The young abused child's pathological bonding relationship to the parent and deeply held self-image of "badness" may lead to distressing symptoms that perpetuate abuse. Such behaviors may include excessive clinging, poor hygiene in the form of encopresis, and severe temper tantrums. Individual case reports of outpatient, modified play therapy programs have described the value of therapeutic play in helping such children (Frazier & Levine 1983; In & McDermott 1976; Jones 1986).

For abused children, who more readily express innermost feelings through action than through verbalization, play is particularly important (Mann & McDermott, 1983). Play is now recognized as an integral part of children's lives. Erikson (1950) indicated that through play the child attempts to understand the rules and regulations of the adult world. Piaget (1962) and Sponseller (1974) both maintain that play is a learning medium. Play, according to Gilmore (1966), is used to assimilate and master stressful experiences. Play allows the child to transform reality and thus develop symbolic representations of the world (Piaget, 1962; Schiller, 1954; Singer, 1973; Vygotsky, 1967).

However, the elements of pretend play require a certain level of cognitive, linguistic, and emotional maturity. These emanate from a relationship with a caring adult who stimulates, facilitates, and models play for the child. Many abused children are poor players whose pretend play may be seen as a disjointed, chaotic puzzle rather than as a way of learning about themselves and the world around them (Irwin, 1983). Through appropriate materials and empathic support, many of these children can be helped to learn how to use play to express, explore, and work through their difficulties.

ACUTE CARE MANAGEMENT

Acute psychological care of the maltreated child will depend upon several variables, including the following: (a) the nature of the injury; (b) the age of the child; (c) previous separations and hospitalizations; (d) the number, severity, and age of onset of past abusive episodes; and (e) the nature of the child's posthospital environment. For recently traumatized children with a limited hospital stay of several days to a week, play can be a vital part of crisis management. The following are aspects of a crisis management program using play: (a) helping the child to cope with loss and separation; (b) helping the child to cope with medical treatment; and (c) assessment of the child's most crucial developmental needs. Children requiring lengthy hospital stays of weeks to months will benefit from a greater range of services that may involve play both as an assessment tool and as a therapeutic modality on an extended basis.

TEAM APPROACH

All members of the health care team make an important contribution to sensitive crisis management and careful assessment of the abused child and parent-child interaction. The child life specialist's skills in using therapeutic play to help children master stressful situations, association with the safe playroom environment, and consistent availability on the unit are key elements in a program designed to provide direct, individualized psychosocial care to the maltreated child. The contribution of the child life specialist is only one aspect of optimal management. These multiproblem children, of necessity, require a team effort within the hospital as well as linkages with court and community agencies. Depending on the institutional organization, various caregivers, such as the child psychiatrist, child psychologist, pediatric social worker, and/or mental health nurse clinician, may use therapeutic play and/or play therapy in addition to other services they provide. In this article therapeutic play encompasses play experiences that assist the child in accommodating to hospitalization, increase the child's capacity to enjoy relationships with other children and adults, and help the child to master fears and anxieties. Play therapy, on the other hand, is conducted within an ongoing psychotherapeutic relationship defined by parameters of time, place, and material.

A child abuse team oversees the medical, psy-

chosocial, and legal aspects of treatment from admission to discharge and follow-up (Besharov, 1983). The child psychiatrist and pediatrician coordinate the assessment and treatment of the child and family by the caregivers. Children with severe symptomatology, such as suicidal attempts and/or ideation, hyperactive-aggressive behavior, and posttraumatic play, require intensive evaluation provided by a child psychiatrist or child psychologist.

Trauma in the Emergency Room

Physical trauma inflicted by others on young children under the age of 5 occurs at an alarming rate, with estimates of 10% of emergency room (ER) visits by children in this age category resulting from abuse (Mrazek & Mrazek, 1985). The ER atmosphere is often one of crisis. The acutely injured, abused child must cope with both physical pain and the frightening awareness that his parents can feel such violent anger toward him. His parents may panic and impulsively flee. In the child's mind, abandonment is proof that he or she "really is bad" and deserves to be left in the strange hospital environment (Jones, 1986; Kempe & Kempe, 1978; Mann & McDermott, 1983).

Before the child has even reached the pediatric unit, he or she may endure a series of charged, traumatic events within the hospital. Child protective workers may question him or her. The child may be exposed to intrusive procedures and unfamiliar equipment. X-rays and photographs may be taken. The child must relate to many strange caregivers and is uncertain of what is going to happen next. If the child's parents have not actually left, they nevertheless may be unable to comfort the child because of their own crippling fears and/or guilt. On the other hand, some parents may be overly solicitous and constantly hovering over the child.

Making Initial Contact With the Child

Play experiences for the child must begin where the child is. A first step is to recognize the pain, confusion, and fear the child may not be able to voice or show in his or her behavior. The bewildered child may not know what he or she is feeling. Indeed, given a history of abuse and/or neglect, the child may never have learned how to label feelings or how to use language to understand feelings or relieve tension (Allen & Oliver, 1982).

For the acutely injured, abused child in a strange environment, basic issues of trust are paramount. Some severely abused young children will benefit only from what Wolfgang and Bolig (1979) describe as Phase I of play development in children under stress—reestablishing trust through body comfort. Through his or her warmth, the child life specialist shows the child that safety and protection will be provided. His or her benign presence, appropriate physical proximity, sensitivity to the child's needs, and honesty are crucial.

On the other hand, many fearful and anxious maltreated children will need to maintain a "safe" distance from the adult. For them, physical closeness and holding are intrusions they cannot tolerate (Jones, 1986). Modification of the initial play setting may include "an open door" or a room large enough to allow such children to withdraw from the child life specialist from time to time (Mann & McDermott, 1983). Highly intrusive play techniques such as the sensorimotor games of Theraplay are contraindicated in work with these children (Jernberg, 1983).

When direct interpersonal contact is too overwhelming for the frightened child, objects are introduced to serve as intermediaries. Communication through two play phones, one for the child and one for the child life specialist, is a useful method for initiating contact with the silent, withdrawn child. From the perspective of a maltreated child, the telephone is a powerful instrument representing a link to the world outside of the abusive home (In & McDermott, 1976). For children with no oral intake restrictions, small pieces of food may be used to reach out to the child. Mann and McDermott (1983) suggest that food, a concrete source of nourishment from the adult, may eventually become an aid in encouraging play.

Through familiar play materials such as puppets, the child life specialist may serve as a mirror, reflecting the sadness, anger, and helplessness the young child may feel (Kempe & Kempe, 1978). The puppet speaks for the child: "My leg really hurts. I'm afraid, too!" The child's response will give clues to whether or not his or her feelings have been validated.

Medical Treatment and Play

Because abused children may have never experienced first steps toward "trust"—trust in their parents, trust in their world—adult caretakers must be aware that issues involving basic trust will be at the core of all work with these youngsters. Maltreated children fear adults and future violence (Jones, 1986; Mann & Mc-

Dermott, 1983; Zimrin, 1986). In their "frozen watchfulness" abused children are extremely attuned to adult behaviors (Kempe & Kempe, 1978).

The fears of hospitalized abused children are compounded by the nature of the hospital experience. Although pain in the hospital is inflicted by caring adults to help and to heal, the child may view medical treatment as another attack by adults. Through play, the child life specialist prepares the child for painful procedures and clarifies the child's distortions. Nurses, physicians, and other health care professionals who provide direct medical treatment to the child assume an equally vital role in decreasing the child's fear and terror. Gentle, supportive comments that are simply and frequently repeated help the child to differentiate the abusive situation from his or her current care. The wails or whimpers of an abused child receiving treatment as he or she paradoxically cries out for the abusive parent create a painful, emotionally charged situation for all involved. A statement such as, "I feel sad, too, when the needle hurts you. We care about you and want the medicine to make you better really soon," is a simple message of concern that allays the caregiver's sense of helplessness as well as comforting the child.

The child follows his or her own unique play agenda in coping with medical restrictions. Play themes "worked through" within the playroom setting during this period are the child's way of mastering or undoing current suffering and trauma (Erikson, 1950; Gilmore, 1966; Wolfgang & Bolig, 1979). The following case example illustrates the process:

> A 4-year-old repeatedly physically abused child would spend hour upon hour sitting on the child life specialist's lap in the playroom as the two together made "playdough meatballs" and "soup" and concocted all textures and colors of birthday cakes. This child's oral intake was rigorously restricted due to serious abdominal injury as a result of a brutal beating. Only after the acute medical crisis had resolved and she was able to eat again could her play expand to encompass the family drama.

Crisis Management

The abused and/or neglected school-aged child in crisis will have his or her own unique needs. The child may ask questions about his or her parents, try to protect the parents, cry for them, or openly ask to be placed in foster care. A safe, "listening" adult will be as important to this child as this adult is to the younger child. Older children may benefit from verbal interaction before play. This listening/verbal interaction is illustrated in the following case example:

> An 8-year-old boy was immobilized due to fractures sustained when a car hit him while he was crossing the street with his mother and sister. The mother, who had had many psychiatric hospitalizations, fled in a panic and could not be found. Only a week before the accident, the child had been returned to mother after placement in an abusive foster home setting. The child life specialist sat with the child as he sobbed and cried and gently gave voice to his concerns: "Kids are sad when they are sick and alone in the hospital. They worry a lot about what has happened to their Moms." Eventually, this child was able to talk about his mother and the abusive treatment he had received in the foster home.

This child's love and attachment to his mother, the only source of love he may have ever known, were not challenged (Frazier & Levine, 1983; In & McDermott, 1976; Jones, 1986). Even in the crisis situation, the child was helped to understand that it was not his "badness" or "unloveableness" that caused his mother to flee (Green, 1978; Ney, Moore, McPhee, & Trought, 1986).

Older, abused youngsters may need to be more dependent on the helping adult than would normally be expected (Green, 1978). It is important to let them take back to their rooms small items, such as pencils or markers, that belong to the child life specialist. Simple "transitional objects" become concrete reminders—symbols of the adult's concern. As with younger children, transitional objects serve as links between the helping adult and the child.

Aggressive and/or destructive maltreated children expect punishment and violent retaliation from adults (Frazier & Levine, 1983; Mann & McDermott, 1983; Zimrin, 1986). The child life specialist models an alternative way of coping. He or she very actively helps the youngster to channel angry feelings into the use of resistive materials such as pounding or molding clay and woodworking.

For younger children, aggressive behavior may be a way of "testing" the adult in establishing a new therapeutic relationship. Through the use of play materials in their relationship with the helping adult, these children learn that aggression will not be met by counter aggression. From the beginning, it is important that the helping adult reassure the child that no one is going to be hurt.

For some abused children, usually when they are older, aggression directed toward others, rather than passivity and withdrawal, overwhelms all other coping styles. "Provokers," abused children whose impulsive acting out provokes anger from their parents, other adults, and peers, have probably learned to equate punishment with love (Brenner, 1984). After much testing behavior, aggression, for many of these children, is replaced by underlying sadness, feelings of deprivation, and longing to be loved (Kempe & Kempe, 1978).

Such children often require nonpunitive, firm, and consistent limits (Mann & McDermott, 1983). Hitting or lashing out at other children or adults is not permitted on the pediatric unit or in the playroom. If verbal methods fail, the child may need to be held and protected from his or her own sometimes intolerable rage. Angry feelings are identified and labeled. A goal for these children is to decrease the negative behavior that elicits anger from others and further damages self-esteem.

The abused child may be unable to cope with the stimulation of a busy, active playroom and may feel intimidated by a large play group. He or she initially may require a one-to-one patient to child life specialist relationship at bedside or in the playroom before being able to handle groups.

Play sessions for maltreated school-aged children may provide choices for creative projects that build self-esteem and a sense of competence. Structured games may be used as long as they permit successful mastery and pride in accomplishment. For example, developing an interest in playing games such as checkers will be helpful to the child when he or she returns to school. School may become a safe setting where the child can develop ongoing, positive relationships outside of the nonnurturing home (Beezeley et al., 1976; Zimrin, 1986).

PLAY ASSESSMENT AND INTERVENTION

Given the special problems involved in engaging the traumatized, young maltreated child as well as the "play disruption" observed by Tisza, Hurwitz, and Angoff (1970) among nonabused young children during the first days of a hospital admission, assessment and intervention extends throughout the child's hospital stay. Play assessment often begins at bedside. The child life specialist visits the child with a small variety of familiar, age-appropriate materials from the playroom. Toys offered may include structured, movable materials such as cars or boats or nonstructured materials such as art supplies. Children who are "poor players" may use materials in a repetitive or stereotyped manner. They may aimlessly move the cars or boats from one area to another or impulsively push one or two cars aside (Irwin, 1983).

The safe, nonthreatening playroom environment offers staff the opportunity to assess the youngster's needs. "Nonplayers" or children who avoid play materials relevant to their condition are telling staff a great deal about the level of their anxiety and defensive behavior (Burstein & Meichenbaum, 1979; Gilmore, 1966). For example, the regressed, inhibited child may often need to learn how to play. He or she may be unable to use toys purposefully. Some children are even unable to identify toys. For such children, the child life specialist may begin by naming the toy (Mann & McDermott, 1983). Simple statements such as "This is a chair. The doll sits in the chair," may give the child permission to begin to hold and manipulate play materials.

By means of the initial play assessment, "play plans" can be developed that begin where the child feels most secure and safe. The child life specialist gradually helps the youngster to increase his or her capacity to enjoy play and to explore a greater range of play activities (Wolfgang & Bolig, 1979), as in the following example:

> A preschool, physically abused child required prolonged inpatient hospital care. She spent most of her "play" time grimly struggling to eke out numbers and letters crowded in one corner of the page. The child life specialist carefully and meticulously imitated her work. The goal was to help this isolated child move from a perseverative, constricted activity into a world of mutual sharing and enjoyment—where adult imitates child and child imitates adult.

Some children are able, through symbolic play, to reenact their "reality," their experience of the home situation. Play becomes a window on both the child's outer and inner worlds that includes the child's fears, confusion, and longings. The child may assume the roles of various family members (Peller, 1959). However, such play is unlikely to occur in the acute hospital setting without the establishment of a trusting relationship with a caring adult over time.

For those children able to engage in symbolic play, attractive, appropriate materials such as a dollhouse with conventional rooms, furniture, and miniature bendable family dolls may en-

courage such play. Conflicts over aggression can be freely and safely expressed with multiple dollhouse figures (Mann & McDermott, 1983). The easy availability of Band-Aids or Scotch tape may become important to the child because they assume a reparative as well as a protective function.

According to Mann and McDermott (1983), hand puppets may present a problem. The child is less free to shift family roles. If the child life specialist, barely disguised behind a puppet, assumes a role in the family drama, he or she may be open to attack from the child, which would serve to further increase the youngster's feelings of shame and guilt. These authors also suggest avoiding war materials because play may become repetitive and ritualistic without addressing the more complex family relationships.

The following examples illustrate some common themes in the abused child's play:

1. The baby doll is bad and is punished, often harshly and severely. The baby doll is hungry and sent to bed. (Child is the aggressor as well as victim.)
2. Mommy doll throws herself over the edge of the table and dies. Baby doll immediately rescues her. (Child assumes roles of both self-destructive parent and her savior and protector.)
3. The doll's eyes are covered with thick hospital tape. (A physically abused 3-year-old child, constantly exposed to mother's lovemaking and pornographic films, attempts to protect herself from intolerable overstimulation.)
4. A 7-year-old physically neglected and emotionally abused girl carefully draws a picture of a smiling, perfectly dressed, perfectly groomed little girl. (The child creates the happy story, happy ending for which she longs and wishes.)

The child life specialist may identify with the baby doll and cry to give voice to the pain and suffering the child is unable to express. He or she may empathize with the baby doll forced into the role of rescuing the parent: "So hard for baby to save Mommy." Misconceptions are both elicited and clarified: "All babies cry when they are hungry." Sensitivity to the child's love, idealization, and ambivalent clinging to the abusive parent is crucial.

Assessment is an ongoing process involving input from all staff members. For example, nurses or teachers may observe a type of play consisting of compulsive, repetitive, unimaginative activity in which the child seems to be cut off from reality. Mesmerized by small objects or repetitive drawings, he or she reiterates over and over again the elements of the abusive experience (Jones, 1986).

Terr (1981) has described the "forbidden games" of posttraumatic play that the child may be unable to share in the playroom. Such play serves to defend the child from recalling intolerable memories and emotions. The child may spend hours alone fantasizing in isolation. Psychiatric intervention is required when this type of play is observed.

Coping With Emergency Placement

Some children, requiring only a brief acute care hospitalization, will be placed in a foster care setting on an emergency basis upon discharge. Helping the child to cope with the transition to placement, even on a temporary basis, is an important component of care. This process may be extremely difficult for both child and child life specialist. The child may cry and protest vehemently.

The use of two dollhouses is a helpful way of introducing foster care to the child (Kuhli, 1983). Similarly, the child and child life specialist may together build the new home with Lego or other blocks. For the child initially unable to "play out" the separation, the child life specialist plans a structured session to demonstrate how a little boy or girl doll will move from one house to another to live with a new family (In & McDermott, 1976; Kuhli, 1983).

The child life specialist explains to the child that "grown-ups who must make sure that children are safe and will not be hurt" have made the decision. The little doll has not caused the loss and separation (Ney et al., 1986). Although the child may initially be an onlooker in the play session, the child life specialist facilitates expression of the child's fears of abandonment and loss. The child requires constant reassurance that placement does not mean punishment (Green, 1978; Mann & McDermott, 1983).

EFFECT OF TERMINATION ON THE LONG-TERM INPATIENT

Leaving the hospital is a stressful experience for maltreated children who have required extended inpatient care. For some children, the safety, predictability, and support the hospital provides alleviates severe behavioral symptoms (In & McDermott, 1976). Once trust is established, abused children may form close attachments to staff members. Premature attempts to disrupt such relationships lead to renewed withdrawal and depression (Mann & McDermott, 1983). Careful planning for termination in con-

junction with child-protective authorities is crucial.

Play sessions, using the two dollhouses concept, offer the child a way of beginning to cope with fears of abandonment and the loss of adults. Play activities such as working with the child to create his or her own hospital scrapbook or communicating through art work are ways of helping the child to negotiate a difficult transition. Small items such as snapshots may be kept by the child as concrete symbols of the child's relationship with the adult.

Some children who require repeated admissions, for example, for extensive plastic surgical repair, may form long-lasting relationships with staff members over months and years. Although the child may actually see the caring adult only sporadically over time, these attachments are extremely important and may "buffer" the child from the most severe psychological sequelae of abuse (Zimrin, 1986).

CONCLUSION

The role of play during the maltreated child's acute inpatient pediatric admission has received little attention in the literature (Kempe & Kempe, 1978). This may be because of the complex, highly charged, emotional, physical, social, and legal issues surrounding the child and family.

The hospital admission offers caregivers an opportunity to use play as a vital resource in both evaluating and directly meeting the special needs of the abused child. The guidelines and suggestions offered in this article are no substitute for careful observation and sensitivity to the abused child's individual needs and responses. This outline is designed to be used creatively and empathetically by health care team members working with the maltreated child. Systematic studies are required to determine what specific play techniques will best serve each child.

Hospitalization is the first step in a long process of healing and rehabilitation. Play, one crucial component of overall inpatient assessment and management, contributes to a sound basis for future intervention and assumes an equally vital role in discharge planning for the maltreated child.

References

Allen, R. E., & Oliver, J. M. (1982). The effects of child maltreatment on language development. *Child Abuse and Neglect, 6,* 299–305.

Augoustinos, M. (1987). Developmental effects of child abuse: Recent findings. *Child Abuse and Neglect, 11,* 15–27.

Beezeley, P., Martin, H. P., & Kempe, R. (1976). Psychotherapy. In H. P. Martin (Ed.), *The abused child: A multidisciplinary approach to developmental issues and treatment* (pp. 201–214). Cambridge, MA: Ballinger.

Besharov, D. (1983). *Criminal and civil liability in child welfare work: The growing trend.* Washington, DC: American Bar Association.

Brenner, A. (1984). *Helping children cope with stress.* Lexington, MA: Heath.

Burstein, S., & Meichenbaum, D. (1979). The work of worrying in children undergoing surgery. *Journal of Abnormal Child Psychology, 7,* 121–132.

Cohn, A. H. (1979). An evaluation of three demonstration child abuse and neglect treatment programs. *Journal of the American Academy of Child Psychiatry, 18,* 283–291.

Erikson, E. (1950). *Childhood and society.* New York: Norton.

Fantuzzo, J., & Twentyman, C. (1986). Child abuse and psychotherapy research: Merging social concerns and empirical investigation. *Professional Psychology: Research and Practice, 17,* 375–380.

Frazier, D., & Levine, E. (1983). Reattachment therapy: Intervention with the very young physically abused child. *Psychotherapy: Theory, Research and Practice, 20,* 90–100.

Gilmore, J. B. (1966). The role of anxiety and cognitive factors in children's play behavior. *Child Development, 37,* 397–416.

Green, A. H. (1978). Psychiatric treatment of abused children. *Journal of the American Academy of Child Psychiatry, 17,* 356–371.

Green, A. H., Voeller, K., Gaines, R., & Kubie, J. (1981). Neurological impairment in maltreated children. *Child Abuse and Neglect, 5,* 129–134.

In, P. A., & McDermott, J. F., Jr. (1976). The treatment of child abuse: Play therapy with a 4-year-old child. *Journal of the American Academy of Child Psychiatry, 15,* 430–440.

Irwin, E. (1983). The diagnostic and therapeutic use of pretend play. In C. E. Schaefer & K. J. O'Connor (Eds.), *Handbook of play therapy* (pp. 148–171). New York: Wiley.

Jernberg, A. M. (1983). Therapeutic use of sensory-motor play. In C. E. Schaefer & K. J. O'Connor (Eds.), *Handbook of play therapy* (pp. 128–147). New York: Wiley.

Jones, D. P. H. (1986). Individual psychotherapy for the sexually abused child. *Child Abuse & Neglect, 10,* 377–385.

Kashani, J. H., & Carlson, G. A. (1987). Seriously depressed preschoolers. *American Journal of Psychiatry, 144,* 348–350.

Kazdin, A. E., Moser, J., Colbus, D., & Bell, R. (1985). Depressive symptoms among physically abused and psychiatrically disturbed children. *Journal of Abnormal Psychology, 94,* 298–307.

Kempe, R., & Kempe, C. H. (1978). *Child abuse.* Cambridge, MA: Harvard University Press.

Kinard, E. M. (1982). Experiencing child abuse: Ef-

fects on emotional adjustment. *American Journal of Orthopsychiatry, 52,* 82–91.

Kuhli, L. (1983). The use of two houses in play therapy. In C. E. Schaefer & K. J. O'Connor (Eds.), *Handbook of play therapy* (pp. 274–280). New York: Wiley.

Lamphear, V. S. (1986). The psychosocial adjustment of maltreated children: Methodological limitations and guidelines for future research. *Child Abuse and Neglect, 10,* 63–69.

Mann, E., & McDermott, J. (1983) Play therapy for victims of child abuse and neglect. In C. E. Schaefer & K. O'Connor (Eds.), *Handbook of play therapy* (pp. 283–307). New York: Wiley.

Martin, H. P. (1981). The neuropsychodevelopmental aspects of child abuse and neglect. In N. S. Ellerstein (Ed.), *Child abuse and neglect: A medical reference* (pp. 95–119). New York: Wiley.

Martin, H. P., & Beezeley, P. (1976). Personality of abused children. In H. P. Martin (Ed.), *The abused child: A multidisciplinary approach to developmental issues and treatment* (pp. 105–111). Cambridge, MA: Ballinger.

Mrazek, D., & Mrazek, P. (1985). Child maltreatment. In M. Rutter and L. Hersov (Eds.), *Child and adolescent psychiatry* (pp. 679–697). London: Blackwell.

National Center on Child Abuse and Neglect. (1981). *Study findings: National study of the incidence and severity of child abuse and neglect.* (OHDS 81-30325). Washington, DC: U.S. Government Printing Office.

Ney, P., Moore, C., McPhee, J., & Trought, P. (1986). Child abuse: A study of the child's perspective. *Child Abuse and Neglect, 10,* 511–518.

Peller, L. (1959). Libidinal phases, ego development and play. In *Psychoanalytic study of the child* (Vol. 9). New York: International University Press.

Piaget, J. (1962). *Play, dreams and imitation in childhood.* New York: Norton.

Rosenthal, P. A., & Rosenthal, S. (1984). Suicidal behavior of preschool children. *American Journal of Psychiatry, 141,* 520–525.

Schiller, F. (1954). *On the aesthetic education of man.* New Haven, CT: Yale University Press.

Singer, J. L. (1973). *The child's world of make-believe: Experimental studies of imaginative play.* New York: Academic.

Sponseller, D. (1974). *Play as a learning medium.* Washington, DC: National Association for the Education of Young Children.

Terr, L. C. (1981). Forbidden games: Post traumatic child's play. *Journal of the American Academy of Child Psychiatry, 20,* 741–760.

Tisza, V. B., Hurwitz, I., & Angoff, K. (1970). The use of a play program by hospitalized children. *Journal of the American Academy of Child Psychiatry, 9,* 515–531.

Vygotsky, L. S. (1967). Play and its role in the mental development of the child. *Soviet Psychology, 12,* 62–76.

Wolfgang, C., & Bolig, R. (1979). Play techniques for helping preschool children under stress. *Journal of the Association for the Care of Children in Hospitals, 7,* 3–10.

Zimrin, H. (1986). A profile of survival. *Child Abuse and Neglect, 10,* 339–349.