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Incorporating Play in Cognitive Behavioral Treatment for Children with PTSD

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Editorial

Cognitive Behavioral treatments (CBT) for children and adolescents diagnosed with PTSD are considered effective and often serves as 'first line' treatments for this population [1-3]. Most of these protocols include modules of psycho-education, in-vivo exposures to trauma related triggers, stress management techniques, parent counseling, and some variety of narrative work or emotional processing of the traumatic experience [4,1]. CBT protocols for children diagnosed with PTSD, such as the Prolonged Exposure therapy for adolescents (PE-A; [4]) and the Trauma Focused CBT (TF-CBT; [5]) were adjusted to meet the developmental needs of children and adolescents. Some examples for such adaptations are using stories as a means for psychoeducation, using drawings to tell the traumatic experience, and involving the parents in the treatment course.

Despite the mentioned-above adaptations to pediatric population, CBT techniques, such as gradual exposure to trauma related triggers, or cognitive restructuring, are often difficult to carry out with young children [6,7]. The limited verbal and abstract thinking skills of young children might hinder the implementation of such techniques [8,9]. In addition, children and adolescents are likely to be impulsive and limited in their self-reflection [10], while an engagement in exposure tasks requires motivation, tolerance for frustration, and insight into one's behavior [7].

The inclusion of play in CBT can enhance the child's engagement and rapport during treatment. Integrating play elements into CBT has been suggested as a means of enhancing the utility of CBT for children diagnosed with anxiety disorders [11,12,10,7], and PTSD [13]. Moreover, play itself can contribute to the child's mental adjustment. In 2018, Schaefer and Drewes review different mechanisms through which play can ameliorate fears and anxieties [8]. For example, play can evoke positive affect and reduce stress, which contradict the negative affect. Imaginative play provides the child a safe space and an opportunity to be gradually exposed to anxiety producing stimuli. Play may also afford the child a sense of control and competence. Through imaginative play and role play children can externalize their difficulties, thus feel less ashamed of it and more capable to overcome it. In addition, play is often a natural mode of self-expression for young children, whose language skills are yet developing.

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These advantages of play may be particularly important in the context of traumatic experience. Greater resilience in children who have been exposed to terrorism has been associated with greater tendency to engage in play; a better ability to plan and play out a coherent, progressive, creative and satisfying narrative; a better capacity for self-soothing; and a greater tendency to engage in a relationship with an adult during the play [14].

Unfortunately, while play may be helpful in processing traumatic events, exposure to traumatic events may lead to a defensive reduction in children's symbolic play [15-17]. When a child is under a threat condition, the sympathetic nervous system activates the fight or flight (F&F) response, or the freeze response. According to the Polyvagal Theory [16], an adaptive coping requires the ability to shift from these 'survival' modes into social engagement state. Play may be one way to activate the social engagement system. Therefore, incorporating play elements during an exposure to feared stimuli may help children to tolerate it and to be de-sensitized to it [19].

In our clinical experience, there are numerous options of integrating play into CBT with children diagnosed with PTSD. For example, play may be incorporated during the in-vivo exposure tasks [10]. The therapist can design the exposure task as play or create a playful atmosphere during the exposure. By creating a playful atmosphere during the exposure task, the child can form new, competing, associations between the stressor and the feeling of enjoyment [7]. An example for such playful exposure task is asking a child to re-visit the place where he was hit by a car as a journal reporter, who wants to write an article about the accident. The child can also be asked to take the role of a photographer, who wants to document the place where the accident occurred.

Play elements can also be incorporated while processing the traumatic memory. This treatment module usually requires an activation of the traumatic memory and re-telling its' narrative. Reminding the traumatic experience might be painful for the child. Thus, many children resist participating in this therapeutic intervention. However, in our experience, when children are offered to construct their story in a playful and creative manner, their cooperation improves. For example, children treated at our PTSD unit are offered to build a three-dimension model of the place where their traumatic event happened, using blocks, clay, or miniature dolls. Each scene of the traumatic event is composed separately and then being pictured, to allow continuous exposure. The child is asked to view the pictures between the sessions, add verbal subtitles to it, or further elaborate on each scene. Other children choose to tell their traumatic experience by drawing a comic's booklet, writing a book, or preparing a presentation. It is important to allow children to choose their preferred mode of expression, to ensure their engagement and rapport.

In summary, young children may have difficulties in adhering to trauma focused interventions, as these interventions require exposure to painful memories and to frightening situations. We suggest that the integration of playful elements into these interventions may enhance the child's engagement and rapport, activate positive affect, and improve the child's tolerance for stress.

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