Play Profile Constructions: An Empirical Assessment of Children’s Play in Psychodynamic Play Therapy

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ABSTRACT
Play assessment can be used therapeutically to determine whether and how play would be an appropriate intervention mode for children with clinical diagnoses, and to track their therapeutic progress. However, detailed and standardized play protocols that can catalogue children’s play behaviors in psychodynamic therapy are not widely available. The aim of this study was to empirically construct profiles of play using items selected from the Children’s Play Therapy Instrument (CPTI), reflecting the complex play patterns of children with mental health difficulties. These constructed play profiles integrate quantitative items associated with cognitive, affective, social qualities of play, as well as children’s coping strategies. The initial session of 62 children in psychodynamic play therapy was recorded, transcribed and coded using the CPTI, and children’s play profiles were computed. The reliability of the play profiles, and their preliminary associations with children’s symptomatic and behavioral functioning were tested. Results showed that the play profiles showed good inter-rater reliability, internal consistency and their associations were in expected directions with the majority of the criterion measures. Given the limitations of the current empirical play measures in clinical settings, the preliminary validation provided in this study of the play profiles add a significant contribution to existing literature.

Introduction
Recent reviews on the curative factors in psychodynamic child psychotherapy have focused on the importance of play in treatment as a target for empirical investigation (Shirk & Burwell, 2010). Young children use play as a vehicle to express unconscious fantasies, conflicts, and reactions to anxiety provoking situations. Through pretend play, they can reenact real or imagined experiences that have emotional meaning for them (Chazan, 2002; Russ, 2004; Target et al., 2005). The play activity, by removing external goals and pressures, allows children to work on their internal states, to construct and reconstruct different patterns of experience without worrying about real world consequences (Bretherton, 1984; Winnicott, 1971).

Characteristic play patterns of children with a clinical diagnosis
Children with clinical diagnoses start psychotherapy with varying capacities to play, and most often these variations are linked to the type and severity of emotional symptoms (Slade, 1994). Some children are unable to play symbolically because they have not developed capacities to differentiate ideas and feelings from concrete realities, and they are unable to treat them as symbolic states that in play can be worked on and transformed (Fonagy & Target, 1996). Therefore, pretend play skill improvement could be an initial treatment goal. Even when a
child is able to play, children with mental health difficulties often present with characteristic play patterns. Children with disruptive behaviors, such as conduct disorder and attention deficit hyperactivity disorder, have been shown to display more negative affect, such as anger and hostility in their play, and as well as lower levels of affect regulation and organization (Butcher & Niec, 2005; D’Angelo, 1995; Singer & Singer, 1990). Anxious children are found to play solitary and have less organization in play (Christian, Russ, & Short, 2011; Grossman-McKee, 1989). Differences in the level of symbolic play and coherence while playing have also been documented between depressed and nondepressed children (Lous et al., 2002). Children diagnosed with posttraumatic stress disorder (PTSD) display constricted affect and repetitive morbid themes in play (Chazan & Cohen, 2010; Gil, 1991; Terr, 1990).

Some studies looked specifically at the relation of play activity, the quality of affect expressed in play, and behavior problems. Child’s narrative incoherence, the content of their representations, specifically dysregulated aggression, and the intrusion of negative atypical themes on MacArthur Story Stem Battery are substantially correlated with parent reports of externalizing symptoms (von Klitzing et al., 2000; Warren, Oppenheim, & Emde, 1996). In addition, in a sample of 6-year-olds, some of whom were exposed to cocaine prior to birth, negative affect in play significantly correlated with both internalizing and externalizing behaviors (Scott et al., 2006).

Another line of research has looked at positive outcomes of play behavior. Developments in the affective, cognitive and social dimensions of the child’s play are found to be closely linked with children’s overall competence in life. The positive effects of good pretend play (play that includes imagination, fantasy, organization, and emotional expression) have been examined cross-sectionally and longitudinally, and results include positive correlations with adaptive functioning, such as coping, adjustment, and emotion regulation skills (Russ, 2004; Singer & Singer, 1990). For example, an improvement of cognitive constructs in play (i.e., imagination, elaboration, quality of fantasy) relates to frequency and variety of coping strategies used by the child over time (Fiorelli & Russ, 2012; Goldstein & Russ, 2000–2001; Russ, 2004; Russ, Robins, & Christiano, 1999) and as well as the development of emotional understanding and empathy (Niec & Russ, 2002; Seja & Russ, 1999). Affect expression in play is associated with more positive daily behavior (Seja & Russ, 1999), and decreased anxiety and psychosomatic complaints (Christian et al., 2011; Grossman-McKee, 1989). Pretend play has been identified as particularly important in the development of social competence. In pretend play, children have the opportunity to act out social situations that facilitate their understanding of the world (Moore & Russ, 2008).

These results point to the importance of play assessment in identifying characteristic compositions of play associated with certain diagnoses, as well as promoting affective, cognitive and social dimensions of play, in order to develop the child’s overall competence. Literature on psychodynamic play therapy research point out the limited number of reliable and valid psychotherapeutic play assessment tools that can differentiate different kinds of play in psychotherapy, investigate their observational reliability, and associate these with children’s presenting symptomatic characteristics (Russ & Niec, 2011). There are a few psychodynamic play measures with limited degrees of empirical support that can be used in investigating children’s play in psychotherapy such as the Play Therapy Observation Instrument (PTOI; Howe & Silvern, 1981), the NOVA Assessment of Psychotherapy (NAP; Faust & Burns, 1991), and the Children’s Play Therapy Instrument (CPTI; Kernberg, Chazan, & Normandin, 1998). However, for all of these measures more research is needed with larger, more diverse populations, and different research teams (Midgley & Kennedy, 2011).

**Children’s Play Therapy Instrument (CPTI): A comprehensive measure of children’s play in psychotherapy**

Children’s Play Therapy Instrument (CPTI; Kernberg et al., 1998) is a psychodynamically informed measure that aims to assess the structure and function of a child’s play activity in psychotherapy. Among other measures, it is the most comprehensive measure in the categorizing the children’s play.
activity in treatment based on psychodynamic constructs (please see the Methods section for a detailed description of the scale).

CPTI involves many steps for rating a child’s play activity descriptively, as well as using various components such as affective components, cognitive components, narrative components (including language), and developmental components (including social development). In the final level of analysis, the rater makes a global assessment, taking into account previously rated CPTI components, in order to rate the coping strategies in the child’s play. These strategies for coping and adaptation can be organized under four profiles of play: Adaptive, Inhibited/Conflicted, Impulsive/Aggressive, and Disorganized. In her book Profiles of Play: Assessing and Observing Structure and Process in Play Therapy, Chazan (2002) explicated the structure of the profiles and it has been summarized below.

The **Adaptive Play Profile** is the uninterrupted, forward-moving play activity, where children show capacity for representation and symbolization of disturbing experiences and fantasies. These children can express a varied repertoire of representations through play characters, think about and imagine comfortably their internal states. They can regulate and modulate feelings, master transitions between feelings without disorganization, affects expressed include an element of curiosity and sustained focus, and negative emotions have a meaningful purpose. Frequently used adaptive coping strategies include a capacity to enjoy the play situation, a capacity to solve situations involving distress and discomfort, which help the smooth unfolding of the play activity.

The **Inhibited/Conflicted Play Profile** portrays a struggle between unconscious conflicting needs and emotions, which find expression through the child’s play activity. Such children have difficulty sustaining free spontaneous play, and they express simple solitary representations, a narrow range of affects, with predominant expression of anxiety and an overall somber tone. Coping strategies such as isolation of affect, rationalization, and undoing are used to handle emotional implications of play narrative in a neutral, factual, objective way, which result in a rigid play structure. These children usually play alone and silently.

The **Impulsive/Aggressive Play Profile** is characterized by an absence in the natural flow of play due to marked outbursts and abrupt interruptions. These children try to cope with disturbing feelings through movement and activity. They rigidly divide the world between the bad and the good because of their difficulty in integrating aggressive feelings, and commonly use strategies such as splitting and denial. Anxiety and the aggression in play are acted out directly in behavior, without translation into symbolic representation.

The **Disorganized Play Profile** is characterized by extreme anxiety. At these moments the child is communicating the fear of becoming completely overwhelmed by strong emotions. Such play involves many disruptions and little facilitation on the child’s part. Play activity may involve sensori-motor activity below the child’s developmental age. Play characters and themes contain bizarre and overly aggressive representations that change without the child’s control. Affect may be extreme, predominantly negative and inappropriate, at times involving intense fears of losing control. The child may lose awareness that this is play and feel surprised or frightened by what comes up.

In a series of single case studies (Chari, Hirisave, & Appaji, 2013; Chazan, 2000, 2001, 2002; Chazan & Wolf, 2002) it was shown that the profiles can be used to document changes across therapy with children ranging from ages 2 to 9 years, and varying levels and types of psychopathology such as Reactive Attachment Disorder, Major Depression, Social Anxiety, Narcissistic Personality Disorder, Borderline Personality Disorder and Pervasive Developmental Disorder. In each case, the profiles provided a valuable tool for empirical study of play with children presenting with different psychopathologies.

**Aims of the current study**

The aims of this study were two-fold. As explained earlier, original CPTI play profiles are based on the global judgment of the rater that brings together qualitatively specific descriptive, cognitive,
affective, and developmental components of the play activity, which assess the overall function of the child’s play. The first aim of this study was to provide an additional quantitative method to group certain CPTI items in the construction of play profiles. This quantitative method is based on the original structure of the CPTI, as well as evidence-based single case studies (e.g., Chazan, 2002) and has the aim of grouping individual CPTI items that work in concert with each other in the construction the profiles. It is put forth in order to systematize quantitatively the underlying structure of the profiles and to statistically investigate how these groups of items work together. The aim is not to circumvent the clinical approach of the scale but to offer an additional quantitative perspective that can be used for empirical purposes.

As part of this first question, internal consistencies and intercorrelations were computed for four the constructed play profiles in order to examine their reliability. To date, only one study has used these constructed play profiles in an evidence-based case study with anxiety disorders (Halfon et al., 2016). In this study, the constructed profiles showed good reliability. A second aim was to test preliminary associations between the constructed play profiles and children’s symptomatic and behavioral functioning, and total competence to provide initial support for external validity. However, as these associations were not examined before, predictions about their direction were not made prior to analyses.

**Method**

**Sample**

**Patients**

The source of data used for this study comes from Istanbul Bilgi University Psychotherapy Research Laboratory, which provides low-cost outpatient psychodynamic psychotherapy and professional training at master’s level for students in the Clinical Psychology Program. Referrals were made by parents themselves or by mental health, medical, and child welfare professionals. The parents and the children were interviewed in order to determine whether the patients fit the study protocol inclusion criteria: ages between 4 and 10 years old; no psychotic symptoms; no significant developmental delays; no significant risk of suicide attempts; and no drug abuse. The patients and their parents were extensively informed before commencing therapy and consented to video recordings and data collection at all times. The parents provided written informed consent, and the children provided oral assent concerning use of their data for research purposes.

A group of 84 consecutively admitted patients from fall 2014 to spring 2016 were screened in the initial meeting by a licensed psychologist, and those who met inclusion criteria were approached for data collection purposes. Of those, 62 patients met inclusion criteria and consented to research and video recording of sessions, and they were included in the initial sampling. The demographic characteristics of the sample are presented in Table 1.

Eighty to ninety percent of the children come from low to middle SES intact families, and approximately 10% of the parents are divorced or widowed. The children’s ages ranged from 4 to 10 years, with a mean age of 6.92 (SD = 2.03). Referral problems manifested primarily as behavioral problems, such as anger management issues, disobedience and not taking limits, followed by school problems such as inattention in class and low grades, followed by social problems, such as difficulties in family relationships or socialization with friends and finally anxiety problems, such as separation anxiety and night terrors. This was a relatively homogeneous sample of children in terms of problem levels, who were mostly at “Borderline” or “Clinical” level of functioning (Mean Total Problem T-score = 64.95, SD = 6.61) on the Child Behavior Checklist (CBCL; Achenbach, 1991).

**Play sessions**

The initial therapy session of each patient was used for data analyses. The treatment model used in the clinic is psychodynamic play therapy. A total of 22 therapists (all clinical psychology master’s
level graduate students) conducted this initial session, with each therapist generally working with one to three patients. The therapists were all women ages 23–27 years. Each therapist was extensively educated in the theoretical background of psychodynamic play therapy and its various applications one year prior to the study. All therapists had the same experience level (one to two years of psychotherapy training), and were supervised by experienced psychodynamic clinicians. In this way, the confounding variables rooted in differences in the educational background, experience, and supervision process were partially controlled.

The clinic has four identical specially equipped play therapy rooms with one-way mirrors and videotaping equipment. The rooms have symbolic toys such as dolls, a doll house and puppets, plastic animals, more aggressive items such as plastic soldiers, combat toys and plastic guns, transportation toys such as cars, ships, planes, plastic doctor materials, such as stethoscopes, vaccines, and a plastic tool box. There are also creative items such as art supplies and clay.

In the initial session, the child is taken to the play room, and after introducing the room, the therapist tells the child that he/she is free to play with any of the materials and the only rules are that he not hurt himself, the therapist, or break any toys. The exploration of the child’s issues takes place in a largely child-led process way, and the therapist encourages the child to express and reflect on his perceptions, feelings and thoughts in play. No other specific therapeutic interventions are employed in the first therapy session.

### Measures

#### Background information
Demographic information, such as socioeconomic status and marital status, was obtained using a standard intake information form and from information obtained in the initial interview with the parents.

#### Behavioral functioning measures
The Child Behavior Checklist (CBCL; Achenbach, 1991) is a widely used method of identifying problematic behaviors in children. For children ages 4–18, a parent or a primary caregiver reports on the child’s academic performance, social relationships, and indicates how true a series of 112 problem behavior items are for the child on a 3-point scale (0 = not true, 1 = somewhat or sometimes true, and 2 = very true or often true). The following syndromes are scored from the CBCL: Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, Social Problems, Thought Problems, Attention Problems, Rule Breaking Behavior, Aggressive Behavior. Anxious/Depressed, Withdrawn/Depressed, and Somatic Complaints syndromes comprise an Internalizing group; the Rule Breaking Behavior and Aggressive
Behavior syndromes comprise an Externalizing group; and Total Problems is the sum of scores on all problem items. The cut-off points for borderline and clinical designation are based on t-scores formed on a clinical population. Back translation, bilingual retest method, and pretest studies were used for the translation of the CBCL (Erol & Şimşek, 2000). The test–retest reliability of the Turkish form was .84 for the Total Problems, and the internal consistency was adequate (Cronbach’s alpha = .88; Erol, Arslan, & Akcakin, 1995; Erol & Şimşek, 2000).

Global outcome measures
The Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA; Gowers et al., 1999) was developed in the United Kingdom for measuring outcome in clinical settings. The HoNOSCA focuses on a range of behavioral, symptomatic, and social impairment domains and consists of 15 scales, each rated from 0 (no problem) to 4 (severe to very severe problem). The first 13 scales are summarized to a total score (range 0–52) indicating severity of mental health problems. The scale is reported to have good inter-rater reliability, test-retest reliability and construct and concurrent validity (Gowers et al., 1999).

Assessment of play activity
Children’s Play Therapy Instrument (CPTI; Kernberg et al., 1998) rates children’s behavior in a therapeutic setting at different levels. For further definition of play activity categories, please see (Chazan, 2002). The scale involves three steps (Chazan, 2000, 2001); (please see Figure 1).

In step one, the child’s activity in the session is segmented by the rater indicating the presence of one, or more, of the following observations: preplay, play activity, nonplay, and interruption. Going forward, only play activity is rated.

In step two, the play activity chosen to be rated (the longest segment) is described in a written narrative, and then the rater proceeds to rate the play activity under different theoretical levels of analyses (descriptive, structural, functional), defining an aspect of play activity. Each of these levels of analyses involve several scales and items, which are all rated using a 5-point Likert scale: 5 = most characteristic; 4 = considerable evidence; 3 = moderate evidence; 2 = minimal evidence; and 1 = no evidence.

Figure 1. Children’s Play Therapy Instrument (CPTI): Selected rating scales (Each scale has several items rated on a scale of 1 (low) to 5 (high)).
Scales in the Descriptive Analysis of play activity take into account the category of the play activity (e.g., gross motor, fantasy, game play), the script of play (e.g., the child’s capacity to initiate and facilitate play), and the sphere of play (i.e., where the play takes place). In the Structural Analysis, the rater then proceeds to rate the play activity on various components, which include affective components (types of affect expressed in play and affect regulation strategies), cognitive components (i.e., how objects and people are represented in play), developmental components (including social development, e.g., how the child plays with another person) and narrative components (e.g., the child’s use of language).

In step three, the Functional Analysis, the instrument has two scales. The first scale assesses coping and defensive strategies on four clusters: Defense Cluster 1 (Adaptive, e.g., adaptation, problem-solving, sublimation, humor), Defense Cluster 2 (Conflicted, e.g., intellectualization, doing and undoing, somatization, avoidance), Defense Cluster 3 (Polarized/Rigid, e.g., splitting, projective identification, omnipotent control), Defense Cluster 4 (Extreme Anxiety/Isolated, e.g., dispersal, fusion, dedifferentiation, autistic encapsulation, freezing). The second scale assesses the degree of the child’s subjective awareness of himself/herself as a player.

Construction of play profiles. The constructed profiles are computed by calculating a composite score using each CPTI item that is associated with the profile (see Table 2).

In order to create the profiles, all the specific items under each profile are summed and then divided by the number of items in that cluster. Because all the items are scored on a scale of 1–5, a standardization procedure is not needed. The specific CPTI items that contribute toward each profile are as follows:

Adaptive profile. Facilitation of Play Activity, Play in Microsphere with Symbolic Toys, Flexible Regulation of Affects, Smooth Transitions between Affects, Pleasurable Affective Tone, Appropriate Affect Expression to Play Content, Voluntary Transformation of Play Roles, Talking about the Play, Use of Adaptive Defenses, High Awareness of Being in a State of Play.

Inhibited profile. Inhibition of Play Activity, Somber Affective Tone, Narrow Spectrum of Affects, Rigid Regulation of Affects, Solitary Play Roles, Use of Language: Silence, Child Plays Alone, Use of Conflicted Level Defenses.

Impulsive profile. Inhibition of Play, Play in Macrosphere via Gross-Motor Activity, Rigid Regulation of Affect, Abrupt Transitions Between Affects, Affect Type: Anger & Anxiety, Involuntary Transformation of Play Roles, Magical Representations in Play, Use of Polarized Level Defenses, Unaware of Being in a State of Play.

Disorganized profile. Inhibition of Play, Affect Tone: Overt Distress, Inappropriate of Affect Expression to Play Content, Involuntary Transformation of Play Roles, Bizarre Representations in Play, Defenses Associated with Extreme Anxiety, Unaware of Being in a State of Play.

CPTI adaptation. Author was trained by Saralea Chazan on the use and adaptation of CPTI. The CPTI was translated and back translated for use in Turkey. A group of seven graduate students and an experienced clinical psychologist with 10 years of clinical experience evaluated the language and statement comprehensibility of the scale. The scale was finalized following necessary modifications according to the feedback received during this evaluation. Two masters level research assistants received 20 hours of training on the CPTI by the Author and rated 10 training sessions (24 play segments) prior to the study. In order to identify the agreement level between judges for subscale ratings, intra class coefficients (ICCs) were computed. The values varied between .75 and .97, suggesting good reliability for all subscales of CPTI. Disagreements were resolved by consultation with the Author.

Procedures

Parents completed the CBCL at the initial assessment session. At the end of the assessment session, the therapist filled out the HONOSCA. Afterwards, the first play therapy session with the child was video-
Table 2. CPTI constructed play profile items.

<table>
<thead>
<tr>
<th>CPTI categories</th>
<th>Adaptive</th>
<th>Inhibited</th>
<th>Impulsive</th>
<th>Disorganized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Script description</td>
<td>Facilitate Play</td>
<td>Inhibition</td>
<td>Inhibition</td>
<td>Inhibition</td>
</tr>
<tr>
<td>Play sphere</td>
<td>Microsphere</td>
<td>Macro sphere</td>
<td>Rigid Affect Regulation</td>
<td>Rigid Affect Regulation</td>
</tr>
<tr>
<td>Affective components</td>
<td>Flexible Affect Regulation</td>
<td>Rigid Affect Regulation</td>
<td>Abrupt Affect Transitions</td>
<td>Overt Distress</td>
</tr>
<tr>
<td></td>
<td>Smooth Affect Transitions</td>
<td>Overt Distress</td>
<td>Anxiety</td>
<td>Expression</td>
</tr>
<tr>
<td></td>
<td>Pleasurable Tone</td>
<td>Anger Expression</td>
<td>Expression</td>
<td>Expression</td>
</tr>
<tr>
<td></td>
<td>Somber Tone</td>
<td>Inappropriate Affect to Content</td>
<td>Inappropriate Affect To Content</td>
<td>Inappropriate Affect To Content</td>
</tr>
<tr>
<td>Cognitive components</td>
<td>Appropriate Affect to Content</td>
<td>Solitary Play Roles</td>
<td>Involuntary and Unstable Transformations</td>
<td>Involuntary and Unstable Transformations</td>
</tr>
<tr>
<td></td>
<td>Voluntary Transformation of Play Roles</td>
<td>Involuntary and Unstable Transformations</td>
<td>Magical Play Roles</td>
<td>Bizarre Play Roles</td>
</tr>
<tr>
<td>Language components</td>
<td>Describing Play</td>
<td>Silence</td>
<td>Silence</td>
<td>Silence</td>
</tr>
<tr>
<td>Social components</td>
<td>Play Alone</td>
<td>Polarized</td>
<td>Polarized</td>
<td>Polarized</td>
</tr>
<tr>
<td>Coping and defensive strategies</td>
<td>Adaptive</td>
<td>Conflicted</td>
<td>Conflicted</td>
<td>Conflicted</td>
</tr>
<tr>
<td>Awareness of being in a state of play</td>
<td>Aware</td>
<td>Unaware</td>
<td>Unaware</td>
<td>Unaware</td>
</tr>
</tbody>
</table>
recorded, transcribed verbatim, and rated by outside judges using the CPTI. Each session was segmented according to CPTI procedures, and the longest segment of each session was used for further CPTI rating and analyses. The play segments ranged from 15–25 minutes (M = 20.45, SD = 6.06).

**Results**

*Internal consistency of the constructed play profiles*

Internal consistency of all play profiles were computed after reversing the relevant items so that high scores reflect the unique characteristics of each profile. The internal consistency of the profiles was tested by Cronbach alpha and the scores varied between .73 and .76 (see Table 3) suggesting good reliability.

*Preliminary inspections of the data*

In order to inspect for outliers, the variables were transformed into z-scores, with one score in the disorganized and one score in adaptive categories, and noncontinuous and outlying z scores (+- 3.29) were truncated, where extreme scores are recoded to the next highest (or lowest) reasonable score based on the distribution of the variable (Tabachnick & Fidell, 2007). This technique reduces the impact of outliers on the analyses, while at the same time accounting for the variance provided by patients, who show characteristics of a particular play profile more often than others. To facilitate comparisons with previous research, untransformed means are reported for play data (please see Table 3).

Prior to testing correlations, the possible contribution of children’s age and gender to the studied variables were examined through preliminary analyses. Children’s age was found to be significantly correlated with CBCL Total Competence (r = -.61, p < .001), CPTI Adaptive Play profile (r = .45, p < .001), Impulsive Play Profile (r = -.40, p < .05). Gender was not significantly associated with these variables.

*Correlations among the four play profiles*

Because connections were found between some age and play variables, partial correlations controlling for age were computed to provide a more comparable picture of the connections between the various profiles (see Table 4).

The correlations were all in expected directions, with the less functional play profiles negatively associated with the adaptive profile and a significant positive association between impulsive and disorganized profiles.

<table>
<thead>
<tr>
<th>Table 3. Cronbach alpha coefficients and descriptive statistics for each play profile.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of items</td>
</tr>
<tr>
<td>Adaptive Play Profile</td>
</tr>
<tr>
<td>Inhibited Play Profile</td>
</tr>
<tr>
<td>Impulsive Play Profile</td>
</tr>
<tr>
<td>Disorganized Play Profile</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 4. Partial correlations among play profiles (N = 59).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variables</td>
</tr>
<tr>
<td>1. Adaptive Play Profile</td>
</tr>
<tr>
<td>2. Inhibited Play Profile</td>
</tr>
<tr>
<td>3. Impulsive Play Profile</td>
</tr>
<tr>
<td>4. Disorganized Play Profile</td>
</tr>
</tbody>
</table>

Note. *p < 0.05; ** p < 0.01.
Correlations between CBCL and HONOSCA subscales and play profiles

Pearson correlations (see Table 5) between play profiles and criterion indices showed that impulsive play profile was negatively associated with CBCL Total Competence and Internalizing Problems, and disorganized play profile was negatively associated with CBCL Total Competence. Looking at the specific associations with CBCL syndromes, it was found that the inhibited play profile was significantly associated with Withdrawn/Depressed and Aggressive Behaviors, and disorganized play profile was significantly associated with Social Problems and Aggressive Behaviors. Moreover, adaptive play profile was negatively associated with Aggressive Behaviors at the trend level of significance (p = .07). HONOSCA Symptomatic Problems was also negatively associated with adaptive play profile, and positively associated with inhibited and disorganized profiles, however these results were all at the trend level of significance (p = .07; .09 and .07 respectively).

Discussion

Despite the fundamental value of play in treatment, measuring the play processes taking place in psychodynamic play therapy has been a challenge. Studies of play assessment in clinical settings stressed how play provides an essential medium of communication for children, and a way to understand their psychological functioning. However, many authors have stressed the shortcomings in the theoretical and methodological models of play, which is a complex function that should be studied taking into account its various dimensions (Russ & Niec, 2011; Shirk & Burwell, 2010). The aim of this study was to use the CPTI to put forth a quantitative method to construct four play profiles, which reflect conscious and unconscious representational, affective, and defensive strategies used by children in psychodynamic play therapy. In the original version of the CPTI, the profiles are based on the qualitative judgment of the rater, and the aim of this study was to provide an additional quantitative method to systematically bring together CPTI items associated with each profile, as well as test their statistical reliability, consistency and preliminary external validity.

The good to excellent inter-rater reliability findings in scoring the videotapes of children’s play activity augment previous findings with the CPTI, and support that following training, play activity can be reliably assessed using the CPTI (see Chazan, 2002 for a review). The internal consistency of the play profiles was found to be good, suggesting both associations between the scales, as well as unique aspects captured by the various scales. Given the limitations in current empirical play measures that can be used in clinical settings, the preliminary validation provided in this study towards the observational reliability and internal consistency of play profiles, add a significant contribution to existing literature. In prior studies, Chazan (2009, 2012) had demonstrated empirical validity of the play styles with a mainstream sample using the CDPI, and this study provided preliminary empirical support for the use of the profiles with a clinical sample with the CPTI.

The second aim of this study was to determine whether the play profiles would be associated with children’s social and emotional problems. Overall, the play profiles showed correlations in expected
directions with the criterion measures. The results showed that Total Competence scales of CBCL, commonly used as the predictors of intact or problematic social skills, activities, and school performance, were significantly negatively associated with impulsive and disorganized play profiles. Moreover, our data also showed that children’s Social Problems on the CBCL was significantly negatively associated with the disorganized profile. Chazan (2012) had found that children showing impulsive and disorganized strategies in play have negative relations with adults and peers, and show deficits in reciprocity and cooperation, and our findings support these results. Moreover, these results parallel prior play research that has shown that children who demonstrate better organization in play tend to be less aggressive in social interactions (Singer & Singer, 1990), tend to perform better in school, and are overall less aggressive and more joyful (Russ, 2004).

Based on prior literature, it was expected that there would be associations between children’s play profiles and behavioral functioning. A negative association was found between CBCL Internalizing Problems and impulsive play profile. Children with internalizing problems are more constricted in their affect expression in play than other groups (D’Angelo, 1995). Also, internalizing children are found to have significantly lower fantasy and affect scores in play (Russ, 2004). In contrast, impulsive play profile is associated with expression of strong negative feelings, and especially anger, as well as competitive themes involving winning and losing (Chazan, 2012). Our findings suggest, in concordance with prior literature, that children with internalizing characteristics are much more somber in play, and have restricted affect expression, which may explain the negative associations with the impulsive profile.

Looking at the specific associations with CBCL syndromes, it was found that the inhibited play profile was significantly associated with CBCL Withdrawn/Depressed and Aggressive Behavior problems. Children with depressive problems have previously been found to be less motivated to engage in play (both play in general and symbolic play), to offer and seek less comfort during play from peers or adults, and show less exploration than their non-at-risk peers (Lous et al., 2002). These characteristics are all under the rubric of inhibited play, such that children showing this play style have been found to also engage significantly less in fantasy play, show no significant interactions with others or between imagined roles (Chazan, 2012). These findings also support the hypothesis that the affect regulatory problems that characterize depressed children have an inhibiting effect on depressed children’s symbolic play (Lous et al., 2002).

The association between the inhibited play profile and aggressive problems was intriguing. Even though prior literature has shown that aggressive children tend to show higher levels of poorly aggressive negative affect during pretend play (Butcher & Niec, 2005), and one would surmise that children with aggressive problems would bring more aggressive affect to their play, it has also been found that expression of aggression in play can in fact be adaptive and is associated with less aggression and more prosocial behaviors in the classroom (Fehr & Russ, 2013). This finding comes from the mastery theory in which children who are able to play out aggressive themes in their play actually show less aggressive behavior in the classroom (Oppenheim et al., 1997; Trotter, Eshelman, & Landreth, 2003; Watson & Peng, 1992). Therefore, it is possible that children with aggressive problems in our sample have limited capacity to use play as an outlet for affect expression (i.e., channel their aggression into the play area), which could ultimately help them to work through or learn to control and regulate aggressive impulses. More research is needed in this area that can differentiate how aggressive children use play in a clinical setting; however, our data showed that these children were more inhibited and disorganized in their play characteristics. The association between disorganized characteristics in play and Aggressive Behaviors on the CBCL have been previously shown in literature (Butcher & Niec, 2005; D’Angelo, 1995), and child’s story incoherence, dysregulated aggression, and the intrusion of negative atypical themes substantially correlated with parent reports of aggressive behaviors (Warren, Oppenheim, & Emde, 1996).

Even though they were at the trend level, the adaptive, inhibited, and disorganized profiles were associated with HONOSCA Symptomatic Problems index. This index is a global measure of the severity of clinical conditions such as depression, anxiety, worries, fears, phobias, obsessions, or
compulsions and psychosomatic symptoms. Children with depression and anxiety have been consistently shown to be poor players in literature, and are reported to have less organization in their play and unable to engage readily in dyadic play (Christian et al., 2011; Grossman-McKee, 1989).

Implications and future research

These preliminary results suggest that these play profile may also be used to differentiate play characteristics of children presenting for psychotherapy and to determine how play may be an appropriate mode of intervention for these children. Results indicate that children with emotional problems, such as depression and aggressive problems, show less adaptive characteristics in their play and are more inhibited and disorganized in their play. They tend to remain centered upon themselves and bring solitary representations to the play field. A treatment goal could be helping these children assume a different role other than their own, without experiencing a threat to their own identity, as well as proceed to activity in terms of reciprocal interactions. They may also benefit from expanding their social repertoire from solitary representations towards multiple roles in play. For constricted, internalizing children, affect expression (both positive and negative affect) can also be promoted as a result of effective therapy. These results also raise the possibility that these children may need initial support in organization of their play, to help use play as a medium for symbolic representation towards working on their emotional issues. The first task of the therapist may be to help the children form the rudiments of a play narrative, and then proceed to finding solutions in play than can contain the intensity of feelings generated within the play relationship without play disorganization (Slade, 1994).

The fact that inhibited and disorganized characteristics are both associated with emotional problems may refer both to a decreased capacity to freely experience various affective states in play and to difficulty maintaining sustained contact with the therapist. These children have previously been found to demonstrate an impaired capacity to play in a truly reciprocal manner and instead use play to control others. The therapist may confront aloofness or disorganized aggression that creates a barrier against a reciprocal relationship (Kernberg & Chazan, 1991). These results have implications for the importance of building a safe therapeutic relationship that may enable the child to play more symbolically in an organized fashion. Chethik (2003) has conceptualized alliance as libidinal attachment where the child, through the process of play can express his/her internal life by using the therapist as a safe other, that is empathic, dependable and available. The therapist also functions as an “affect-regulator” helping the emergence of intense affect without play disorganizations while maintaining the therapeutic bond.

Moreover, these play profiles can be used in a process-outcome design, to examine whether there are consistent changes over therapy hours, as well as their relative importance to the treatment over time. An increase on adaptive play profile could be an indicator of treatment effectiveness. Children who initially score high on the disorganized play profile may need an initial preparatory phase as suggested above. Moreover, because change in psychodynamic psychotherapy is not a linear progress, over the course of treatment, the emergence of inhibited, impulsive and disorganized strategies could be ways of reenacting certain problematic situations in play, which can cause temporary stagnation, however as long as the child continues to play symbolically, adaptive strategies are also used as part of an overall coping effort to master these problematic scenarios (Chazan, 2002). In fact, Halfon et al. (2016) found that over the course of long-term psychodynamic psychotherapy with three children diagnosed with separation anxiety, children oscillated between inhibited and adaptive profiles in face of the emerging issues, which afford the children the opportunity to try out new strategies and revert to old ones when their stress is too high, that helps restore stability toward generating something new.

Several caveats and limitations of these results are important to mention. First, the small sample size and the lack of control group restrict the generalizability of the results. Some of the correlations with low effect sizes that were not statistically significant in the current study may be statistically
significant with a larger sample size. It is also necessary to carry out future validity studies with different criteria that relate to play functions. In addition, despite the similarity in characteristics of the therapists in this study, controlling for therapist effects is also necessary. Finally, even though we controlled for children’s ages, we were not able to account for certain background variables such as children’s level of literacy through psychometric tests, which may have affected some of the variance in our results. However, overall the findings provide systematic quantitative indicators in play activity that can contribute to research on mechanisms of change in psychotherapeutic processes with children, and continued investigations in this vein may prove fruitful.

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