Chapter 10

Containing Feelings and Setting Limits in Play Therapy:

Working with Aggression

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Chapter overview

This chapter will explore the role of the play therapist in responding to children's emotions within play therapy. I begin by discussing how theories of emotional development and new understanding from neuro-biology can inform play therapy practice. In particular, I will focus on responding to aggression within both children's play and within the therapeutic relationship. I will consider the role of limit-setting in supporting emotional development and end with a brief reflection on the importance of therapist self-awareness, as a core aspect of effective therapy.

Play therapy and emotional regulation

Child-centred play therapy pays particular attention to the emotional processes of children within their play interaction. Axline (1989:69) established the centrality of emotions as a therapeutic focus within her principles of play therapy, through her emphasis on empathic reflection 'the therapist is alert to recognise the feelings the child is expressing and reflects those feelings back to him in such a manner that he gains insight into his behaviour'. Indeed,

this early emphasis on empathy has become a fundamental aspect of play therapy practice, reflected in the British Association of Play Therapists' core competences for practice (Core Competences 5, 11, 26. See appendix 3). Landreth (2012) emphasises the significance of the therapist's ability to offer acceptance of the child's emotions, whilst providing safe limits for their behaviour. This acceptance without judgement is at the heart of Rogers' (1951) original core conditions for person-centred practice.

A number of change mechanisms have been identified within play therapy (Russ, 2004), including catharsis, defined as the release of deep emotion, the provision of a corrective emotional experience with the therapist, and promoting the mastery of feelings and behaviour through rehearsal within play. These processes emphasise the role of the therapist in labelling and containing emotions, thereby supporting cognitive development and neurological re-structuring (Drewes & Schaefer, 2014). The therapist's role is to facilitate the expression of emotions, but also to help the child identify and differentiate their feelings. Fonagy (2004) has proposed the broader concept of 'mentalisation' to describe the process by which children come to understand their thoughts and feelings, through the minds and narrative feedback of the adults around them. Within the play therapy relationship, the therapist consciously utilises both emotional and cognitive processes within the play, building the child's emotional understanding and supporting their overall executive functioning (Kestly, 2014).

Schore (2016) highlights the importance of the child's growing ability to identify and regulate their emotions, as a vital aspect of healthy psychological development, particularly important for managing negative emotions, due to the powerful physiological arousal of such feelings. This regulatory ability develops within the context of the primary caregiving relationship, and mostly through the nonverbal and sensory interaction of parent and child. (Stern, 1985) Gaskill (2014) describes the role that 'mirror neurons' within our brains play in supporting a sense of inter-subjective sharing within both the parent-child and therapeutic

relationships. This shared connection is communicated largely through 'vitality matching' (Patton and Benedict, 2016), whereby the therapist conveys the intensity of the child's feeling through their tone and facial expression, whilst also marking their experience as sufficiently different to convey mastery and self-management, promoting 'co-regulation' of emotional states (Schore, 2016). For example:

Reuben is a 10-year-old boy in a kinship placement with his maternal aunt. These excerpts of play are taken from his fourth and fifth play therapy sessions with me:

<u>Week 4:</u> Reuben is using the Incredible Hulk figure to fight a large army of soldiers

R: (Excited, aggressive tone) They are all firing at the Hulk but he is smashing them down (knocks the soldiers down with Hulk's powerful hands) Ha, they can't hurt him!

Therapist: (Matching excited tone and gestures) The Hulk is fighting them all, and he feels strong and powerful. They cannot hurt him!

R: (Determined, powerful tone) Smash! (Hulk slams into the soldiers again, stamping up and down on them) Hulk is smashing them all up, but they can't touch him

Therapist: (Trying to match the strength of this tone) Hulk is stamping all over them but they can't get him. No one hurts the Hulk.

R: (Pointing to bruises on his arms and legs) I fell off a shed roof, but it didn't hurt. Nothing hurts me – if you hurt me I get stronger (Excited, proud, strong)

Therapist: (Reflecting his strong confident tone) you feel so strong, it's like nothing can hurt you… it makes you feel stronger ... But I would be frightened if I was climbing on a roof. Those cuts look really sore to me. (Shifting to worried, but animated tone to match shift in content)

R: (Less powerful, more questioning tone) don't you like being hurt? I don't care about getting hurt.

Therapist: (Conveying uncertainty, confusion) it's confusing, even when things hurt, you don't mind, you even like it …so hard to know how to feel. I don't like being hurt - it makes me sad.

Week 5: The following week Reuben came into the session and immediately showed me his finger, where he had a tiny, almost indiscernible cut.

R: (Vulnerable, childlike tone) I hurt myself – I cut my finger.

Therapist: Oh, you hurt yourself this week and you are showing me. It really hurt and you noticed it …I think we need to take care of this hurt. Shall we find a plaster? (We go to the first aid box to dress his finger. I stroke it gently with cotton wool) we need to look after your finger because it hurts. You really felt it. (Gentle, singsong, rhythmic tone to convey calm concern)

Here, Reuben is exploring a number of emotional themes within his play, including aggression, but also, tentative expressions of vulnerability and nurture-seeking. My tone matches Reuben's, but my facial expressions and posture convey interest, concern and acceptance, rather than aggression. Through my acceptance of these ambivalent emotions, Reuben is able to begin to identify and name his feelings more easily and to express his needs, both within the therapeutic relationship and then within his play.

For some traumatised children, play therapy can be a threatening experience, leading them to avoid engaging with the therapist. Perry (2007) stresses the importance of establishing a primarily sensory connection with such children, to support co-regulation of their stress reactions and help calm their defences. Barfield et al. (2012) emphasise providing patterned,

sensory experiences, to help the child to soothe their arousal. Play therapy utilises a range of ways to provide this through rhythm, music, movement and touch. For example:

When I began working with 11-year-old Tyrone, he refused to speak and hid away in a den, separated from me by blankets and chairs. After a difficult 30 minutes, he began to tap out a rhythm on the floor pushing his hand through the blanket and into view, while the rest of him remained hidden. I sat nearby on the floor and joined in tentatively, until we gradually began to beat out a rhythm together. Over several weeks, we developed elaborate tunes together on the drums and at his suggestion, began singing nursery rhymes and songs. By this point, Tyrone had emerged to sit opposite, smiling and looking straight at me. He was now ready to explore the playroom.

Badenoch (2008) describes how this process of co-regulating emotions at a sensory level with the child, supports the development of more complex neurological pathways within their mid-brain and limbic system, which can help the child begin to exercise greater levels of control over their subsequent responses. For Tyrone, this experience of regulation enabled him to begin to think about and represent his experiences and feelings through symbolic play.

Understanding and responding to aggressive play

Ray (2011) describes aggression as a developmentally ordinary aspect of children's development, emerging around 18 months of age, often associated with frustration about wish fulfilment or interaction with others. Research suggests that aggressive behaviour usually peaks relatively early in childhood (Doherty & Hughes, 2014), as pre-school children begin to develop cognitive skills to support their social interaction. There appears to be a correlation between poor emotional regulation skills in early childhood and the incidence of aggression in later childhood (Röll, Koglin & Petermann, 2012).

Crenshaw and Mordock (2005) suggest that the development of more entrenched aggression relates to difficulties with a child's emerging sense of autonomy, leading to feelings of shame and inferiority. Many children we meet have experienced adverse life experiences, which can profoundly affect their emerging sense of self, with consequences for their emotional and social development. As a result, aggressive or impulsive behaviour appears to be one common cause of referral to play therapy (Foulkrod & Davenport, 2010). Play therapists need to be able to respond to aggression expressed both directly towards them, in the form of limit-testing and challenging behaviour, and also indirectly, through aggressive themes represented within the child's symbolic and role play interaction.

O'Sullivan and Ryan (2009) identify the importance of helping the child become aware of a range of underlying feelings that might initially present as aggression. They stress the importance of accepting children's aggressive impulses as part of them, worthy of respect and recognition. We must seek to focus on the underlying intention within the child's play, rather than simply tracking the aggression (Norton & Norton, 2002). The task here is to connect with the meaning and energy behind the action, rather than focus on the act itself.

A number of research studies have supported the efficacy of child-centred play therapy in reducing aggression (Schumann, 2010; Ray et al., 2009). Crenshaw & Mordock (2005) identify a wide range of play themes relating to aggression, including domineering and controlling play, representing experiences of trauma, abuse, separation and loss experiences, alongside attachment and nurture themed play. I find it helpful to provide a range of materials that support emotional expression, including dressing-up materials, toys and symbols that represent conflict and aggression, for example soldiers, police, superheroes, monsters and dinosaurs. However, children will make use of whatever materials are available, including sensory materials such as sand and clay, competitive games, small world toys and nurture play materials. Indeed, some of the most aggressive play I have witnessed has involved

nurture materials, such as baby dolls, family figures and stuffed animals, as children have sought to represent the pain of early attachment relationships and release deeply held emotions through cathartic play.

A number of developments in contemporary inter-personal neurobiology also influence my practice. Siegel (2012) has shown how early traumatic experiences significantly impact the structures and integration of the developing brain, leading to children who become over-sensitised to potential triggers for danger in their environment, while simultaneously having reduced access to higher brain functions to support cognitive, problem-solving skills. Such children can re-create these experiences in visceral and compulsive ways within their play, and are more likely to present us with aggressive themes and behaviour within the playroom. At times, this will include cathartic play, involving the release of apparently extreme emotions (Drewes & Schaefer, 2014). I have found it important to pay particular attention to children's initial attempts at cathartic play, noting the duration and intensity of play themes and emotions, without restriction where possible. Such play may include intense expressions of anger, fear, revenge and sadness, which the therapist needs to accept without judgment or interference. However, for catharsis to be truly therapeutic, the play therapist will need to come alongside the child, matching their tone and pace to provide a narrative which accurately conveys understanding and acceptance, leading to a gradual reduction in the intensity of expression and an increase in the child's cognitive processing of their emotion (Drewes & Schaefer, 2014). At other times, children may engage in post-traumatic re-enactment, and may require a more structured, psycho-educational response from the play therapist to support resolution of their experience (Gil, 2011 See also chapters in this volume by May and Waycott & Carbis).

Porges' (2011) polyvagal theory identifies that our autonomic nervous system supports us to react to emerging threats within our environment. Chronic exposure to danger causes

children's nervous systems to activate fight or flight responses at an unconscious, sub-cortical level. Importantly, Porges and Daniel suggest that real play can only occur when children are in a relaxed state, - the 'social engagement' mode (2017:115). This occurs when the child's central nervous system experiences safety and the absence of threat, enabling the child to be open to social connections. Play therapy can create the conditions to promote this safe environment, by enabling children to explore their experiences in pretend mode (See Daniel's chapter in this volume for a detailed account of polyvagal theory in play therapy) .Thus for some children, aggressive behaviours within their play may reflect the activation of their autonomic nervous systems as they seek to integrate past experience. The therapeutic task here is to support the child to explore and represent their experiences within the safety of their play. In this context, we are seeking to support the child to optimise their arousal, extending their 'window of tolerance' (Siegel, 2012:281) whilst benefitting from the security of the therapeutic relationship.

To facilitate this, the play therapist will again rely mostly on playful mirroring to communicate understanding and safety, both within the child's symbolic play and in response to the child's limit-testing behaviour with the therapist. Dion (2015) argues that within their play, children represent their neurologically hardwired brainstem responses of either fight /flight, characterised by aggression and conflict themes in the play (hyper-arousal), or as freeze /avoidance, leading to helplessness/ sleep/ death themes within the play (hypo-arousal). Dion suggests that therapists will need to modify their responses to match the arousal of the child's nervous system accordingly. When responding to aggression, it is worth repeating that the therapist's tone and facial expression should match the child's closely, but that the mode of communication and the therapist's active response must be different, so that the child experiences acceptance and recognition, rather than a stimulus that might escalate their aggression. For example:

During the first 6 sessions in the playroom, 6 year-old Matthew, a looked-after child, repeatedly played out scenarios using various wild animals, dinosaurs and monsters. While the characters varied, each story was essentially the same, involving a boy who was constantly in danger from enemies. He introduced a mother figure who came to protect him but became a source of danger, abusing, imprisoning and eventually killing the child. As the therapist, I sought to contain and reflect the extreme emotional themes of this play, including fear and danger, hope for protection and betrayal.

Across 10 sessions, Matthew's play themes continued to reflect his ambivalence about family security and parental caregiving. As the therapist, I made reflections as if I were the child in the play, often relying on my tone and facial expressions to capture my sense of what the play conveyed. For example 'I just don't know if I can trust that mummy dragon, sometimes she looks after me and sometimes she frightens me'. I also gave my own authentic responses to the play themes: 'I am so worried about this child. Who is going to take care of him?' After some time, Matthew introduced a new protective mother figure into his play, in the shape of a large polar bear, who protected the child consistently from week to week. While the sources of danger remained, there was a noticeable drop in the level of aggression within his play. Matthew also began to take notice of me directly in the session, commenting on my facial expressions and that I was a 'good grown up'. There was a sense in which he was actively becoming aware of the adults around him as a potential resource to help him. His carers reported gradual improvements in his responsiveness within the placement.

Matthew's aggressive play combined elements of traumatic re-enactment and catharsis. At times, it felt difficult to contain the sense of hopelessness and maternal aggression which seemed to represent his lived experience. However, by mirroring the emotional tone of the play, my presence offered safety and emotional acceptance to Matthew, as well as validation through the sharing of my own congruent feelings about the welfare of the children within the

play. This seemed to help Matthew achieve some distance from his lived experience and he was able to sustain the play, expressing a range of emotions, whilst developing a new, more hopeful play narrative. In this way, the traumatic aspects of the play reduced and Matthew began to explore a wider range of feelings.

Limit-setting in play therapy

The provision of therapeutic limits within play therapy is a key mechanism to help the child to remain within their 'window of tolerance' by keeping the play environment safe and secure for both participants. Effective provision of therapeutic boundaries and limits is one of the core competences for BAPT accredited play therapists (Core competence 22, see Appendix 3).Norton and Norton (2002) suggest that a period of limit-testing is to be expected in most play therapy interventions, as the child explores the trustworthiness of the therapist.

Play therapists often begin and end sessions with a phrase that seeks to convey the permissiveness and consistency of the playroom and relationship. For example, I might say "Alyssa, this is our time in the playroom. You can do most of what you want to do in here, and if something is not OK, I will let you know". However, even in this initial limit, practice varies and many therapists would prefer to emphasise permissiveness at this stage. Ray (2011) suggests that introducing limits too early within therapy can activate resistance for children with oppositional or aggressive traits. For me, conveying that the play space is permissive, but boundaries are present, feels authentic and allows children to begin to explore the therapeutic limits of the experience directly.

Landreth (2012) devised what has become a widely used technique for limit-setting within child-centred play therapy with his acronym 'ACT' (2012:273) - in which the child's feelings in the moment are **acknowledged**, the limit on a specific behaviour is clearly **communicated** and an alternative behaviour is identified (**targeted**). For example:

Laura: (Unexpectedly starting to throw Velcro balls at my face) I can throw these really hard.

Therapist: You are feeling very strong and want to throw those really hard, but I am not for throwing at… you can throw them hard at that target (directing her to the back of the door) if you want to…(watching her throw)… You want to throw them as hard as you can.

Significantly, Landreth (2012) emphasises the importance of patience and persistence when setting limits, using this process a **minimum** of three times before escalating further. This sequence forms an important aspect of emotional containment within play therapy by supporting the child to identify their emotion, while also exercising some autonomy over their action. Within my own practice, I have come to value the process of limit-setting, as providing an opportunity to work with the child's underlying anxiety – whether it be their need for control arising from a lack of trust, or their destructive impulses emerging from a distorted sense of self.

When children are struggling to accept a limit, I usually add an additional empathic statement at the end of the limit (Cochran et al., 2011). This might include re-stating the child's original feeling, or alternatively, naming a newly emerged emotion in response to the limit being set. By returning to a recognition of the child's emotion after the limit has been set, the sense of shared understanding and acceptance is heightened for most children - for example: "You're disappointed that I set that limit, feeling very cross about that". It is not unusual to have to work hard to repeat and sustain limits for children, particularly in the initial stages of therapy, or as the intervention moves towards termination.

While I will seek to facilitate expressions of aggression within play sequences, it is important to manage direct expressions of aggression towards the room or myself, through careful setting of limits. For example:

During my early sessions with Matthew, he also tested the limits of the playroom directly through his behaviour. During our play fighting, using foam bats and play swords, Matthew initially sought to inflict pain on me directly, hitting my knuckles and knees hard and invading my personal space. He mocked and belittled me, as well as subjecting me to frequent violent assault and extended death sequences within our play. It felt that he was expressing some profound feelings of rage towards adults in general. Within my responses, I sought to engage with his aggressive play and acknowledge his angry and destructive feelings, whilst setting limits to keep me safe:

"You are really enjoying this fight and feeling very strong… it feels horrible being cut up and killed". (Reflecting the feeling with my face and tone).

He lunges for my knuckles with his sword –"You feel so angry, and want to hurt me for real and show me how strong you are - I am not for hurting. You can hit my sword or hit my arm here with the foam bat"(I show him the length of my forearm as a limit) "but I am not for hurting"(repeating the limit with a calm tone) "feeling fed up that I won't fight for real" (final empathic reflection).

I needed to repeat this sequence a number of times with Matthew during the first weeks of our play together. Gradually, as he experienced my ability to set and keep limits and my concern for the safety and wellbeing of us both, his aggression reduced and he accepted the limits of the session more easily.

Some psychodynamic therapists emphasise the importance of providing resistance for children, to enable them to begin to experience a sense of agency and mastery as they push against therapeutic limits (Bellinson, 2009). I have met some children who have tried to beat me into submission, regardless of size, and others who seem floppy and listless, physically underdeveloped in their play. These children may require more than basic limit setting to

support their development. McCarthy (2007) discusses the importance of the therapist being strong enough to offer both resistance and at times provocation, to facilitate the child's expression and release of pent up emotional energy. This will also be true for children who demonstrate dissociation or avoidance within their play (Dion, 2015). Levine (2017) discusses the importance of proprioception as a sixth sense, which supports the child's sense of physical self and presence within the world. Engaging energetically in push-pull games such as tug-o'-war or dodge ball with an active child or quietly engaging with the sensory experience of an avoidant or reluctant child to encourage movement and connection, as with Tyrone, are equally crucial aspects of play therapy practice. They support the child's sensory integration and developing sense of their own physical agency, requiring a flexibility in our approach to limit setting.

Both Landreth (2012) and Ray (2011) recognise that initial limits do not always work and that a further step in limit-setting may become necessary, where the child is provided with a choice relating to the limit. Returning to my example with Laura:

Therapist: Laura, it's so hard not to throw the balls at me and you are feeling cross about it, but I am not for throwing at… If you choose to throw the balls at me, then you will be choosing not to play with the balls any more today.

Such limits must continue to be offered with acceptance and warmth to the child. I have noted a tendency in many trainee therapists to escalate quickly to this stage of limit setting, driven perhaps by their own anxiety and need to retain control of the situation. There is a temptation to set an 'ultimate limit 'of ending the session prematurely, in order to restore our own sense of control and efficacy. However, this really does need to be a last resort and I find I rarely need to do this if I can authentically connect with the child's feelings. Since the

therapeutic relationship is the primary vehicle for change in play therapy, it is important to sustain the opportunity for relationship whenever possible.

Therapist's use of self

Offering acceptance in the face of children's aggression and at times overt hostility is challenging. It is important to maintain a deep awareness of our own defences and vulnerabilities, recognising that each of us will find particular issues or types of play challenging and we may need to work hard to maintain appropriate therapeutic limits. It is crucial for play therapists to be continually mindful of their own emotional responses within sessions and to be aware of personal experiences that might trigger transference reactions within the therapy relationship. Particularly when setting final limits for children, there is a danger that our own internal models of behaviour and parenting may intrude on our ability to offer unconditional acceptance and warmth. Additionally, we may have experienced inter-personal trauma, aggression or violence ourselves and will need to have resolved those experiences sufficiently to be able to tolerate exposure to potential triggers within the children's play.

BAPT trained therapists are expected to engage in personal therapy during their professional training and to make use of regular clinical supervision to enable them to reflect on their reactions to children within therapy(Core Competencies 13 &14.See Appendix 3 and other chapters in the volume by McCann and by Platteuw).Through supervision, I also realised I needed to work on my ability to offer resistance and to be an object against which children could push, without triggering punitive or rejecting responses within me. Cochran et al. (2011) remind us that children can also challenge us by being overly compliant or conformist, eager to please or seek approval and that we need to be conscious of how these strategies might impact us also.

Ray (2011) highlights the importance of maintaining our own emotional health and developing our ability to sustain empathy and acceptance in the face of aggression and limit-testing. This will require practice and using supervision to reflect on previous experiences that have proved challenging. There appears to be a high level of consistency amongst play therapists on the type of limits viewed as appropriate (Landreth & Wright, 1997), most specifically around limiting aggression towards the therapist and play materials, and managing dangerous or unacceptable behaviour. At a basic level, these limits support the ability of the therapist to maintain the therapeutic conditions for relationship. Norton and Norton (2002) distinguish between absolute limits, common to all therapy processes and reactive limits, imposed by individual therapists in response to children's particular play, to help maintain the therapeutic relationship. These limits will vary widely and are likely to reflect the character and life experiences of both child and adult to some extent. I recall in my early days of training, my own struggle with offering sufficient acceptance of children's highly messy play, particularly when it appeared to be a deliberate act of testing or defiance by the child. I needed to reflect on this experience within my own personal therapy and recognise the connection with the values of my own upbringing. This helped me to become aware of my responses within children's sessions and begin to offer a greater level of acceptance, eventually taking pleasure in their -and my own - ability to create mess in the playroom.

Ryan and Courtney (2009) have argued for the active use of congruence by the therapist to support the child's understanding of the therapist's emotions and enhance the effectiveness of the relationship. This might involve talking about our own emotional processes and thoughts about the content of the play or the child's behaviour. For example, "*Oh I don't like having balls thrown in my face, it hurts*" whilst also acknowledging the child's intent: "*You felt cross, you really wanted to hurt me when you threw that*". Such responses seek to provide

the child with feedback about the therapist's experience, building their capacity for empathy and perspective taking, whilst also offering the experience of regulation and acceptance so necessary for play. I have found it particularly effective to also notice moments of heightened enjoyment in the play with the child and to recognise our shared relaxation and pleasure, as a key process for building trust and security in the therapeutic relationship. Dion (2015) also suggests that the therapist comment on their own bodily sensations and responses to support the child's growing awareness of their own physiological arousal, for example, *"I'm feeling hot and my heart is beating fast. I'm going to breathe deeply for a moment*".

As therapists, we need to remain open to challenge about our therapeutic practice and to utilise supervisory relationships to enhance our own self-awareness. Congruence and ongoing reflection are important tools in the process of providing an effective play therapy relationship, that will ultimately support the emotional and cognitive development of the child and enable them to understand and manage their feelings more effectively.

Summary

- While children usually develop cognitive and social skills to support the regulation of aggression, adverse life experiences and relationships can undermine healthy development. Persistent aggression tends to be more common amongst these children.
- Play therapy promotes the development of both emotional regulation and neurological integration and can support the development of executive functioning to support new self-management skills.
- Play therapists seek to facilitate the expression of deep emotions, including aggression, within children's play, whilst managing to contain emotions within the therapeutic relationship.

- The use of therapeutic limits within play therapy is one means of promoting safety and creating optimal conditions for the processing of traumatic experiences through play.
- Play therapists must be aware of their own histories and emotional responses and make use of clinical supervision and personal therapy to understand and manage these responses.

Further reading

Crenshaw, D. & Mordock, J. (2005) *Handbook of Play Therapy with Aggressive Children*. Lanham, Maryland: Jason Aaronson. A valuable resource integrating theoretical frameworks for understanding aggressive play alongside practical tools and techniques for working with children.

Dion, L. (2015) *Integrating Extremes: Aggression and Death in the Play Room.* New York: Aviva Publishing. A brief, engaging attempt to integrate learning from neuroscience and trauma with children's fight, flight and freeze responses within their play.

Kestly, T. A. (2014) *The Interpersonal Neurobiology of Play: Brain building interventions for emotional wellbeing*. New York: W.W Norton & Co. Very helpful source for play therapists, which presents complex neuroscience and theories of trauma in a clear and applied way to play therapy processes.

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