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INTEGRATING PLAY THERAPY IN THE TREATMENT OF CHILDREN WITH OBSESSIVE-COMPULSIVE DISORDER

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While behavioral and psychopharmacological approaches are the most effective interventions for treating obsessive-compulsive disorder (OCD), psychodynamically oriented play therapy can enhance the treatment of children with this disorder. Play therapy techniques are useful in addressing treatment resistance, feelings of shame around OCD symptoms, negative self-concept, and issues of psychosocial adjustment. A case study illustrates this integrated approach to treatment.

In recent years, a growing body of research has reported on the efficacy of a range of techniques used to treat obsessive-compulsive disorder (OCD). Behavioral and psychopharmacological interventions have consistently emerged as the most effective treatments *(Abramowitz, 1997; Greist, 1991; Leonard, Rapoport, Swedo, & Koby, 1990; March, 1995)*, although they have revealed certain shortcomings.

Psychopharmacological treatment, valued for the speed with which it can induce changes in thought and behavior patterns, is viewed as a way to manage the disease rather than as a cure *(Flament & Vera, 1990)*. The specificity of behavioral techniques, such as graded exposure and response prevention, contribute to their potency, but can also detract from their ability to promote overall healthier psychological functioning. Flament and Vera *(1990)* argued that behavioral techniques, focused on treating obsessions and compulsions, usually do little to address the problems that frequently accompany OCD, such as generalized anxiety or depression. Successful implementation of behavioral techniques also requires a high level of effort and compliance on the part of the patient; consequently, resistance to change can severely inhibit the efficacy of behavioral treatment methods.

While behavioral and psychopharmacologic techniques form the cornerstone of effective OCD treatment, other approaches have gained support as beneficial adjunctive services. Family psychotherapy is one such approach, particularly in the treatment of children and adolescents *(Johnston & March, 1992; Lenane, 1991; Leonard, Swedo, & Rapoport, 1991)*. In such circumstances, family therapy teaches parents to discontinue their participation in their youngster's rituals *(Lenane, 1991)*. Some

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family therapists reframe the meaning of patients' obsessions and compulsions, so that the patients' behavior acquires a different meaning for the family *(Leonard et al., 1991)*. Family therapy also provides psychoeducation and social support for families coping with a stressful disorder that often disrupts family functioning *(Johnston & March, 1992)*. Other innovative adjunctive treatments discussed in the literature include group therapy, multifamily group therapy *(Van Noppen, Rasmussen, Eisen, & McCartney, 1991)*, and cognitive therapy *(Sherman, Ellison, & Iwamoto, 1996)*.

In contrast to the support given to other adjunctive approaches, psychodynamic OCD interventions *(Flament et al., 1990; Greist, 1991; Jenike, 1990)* are frequently shunned. Research has shown that psychodynamic techniques are ineffective in altering the thought and behavior patterns of the disorder *(Johnston & March, 1992; Sherman et al., 1996)*, and some of the most respected psychoanalytic thinkers have admitted that their theories and approaches have been unsuccessful in treating patients with OCD. For example, Anna Freud *(as cited in Fenichel, 1945)* noted that analysis with OCD patients typically proved difficult or impossible, given that their pathology was located in their thinking processes, and thus strongly limited their ability to communicate in analysis. More recently, critics have implied that psychoanalytic formulations of OCD's etiology seem archaic in light of much evidence supporting a neurobiological understanding of the disorder *(Johnston & March, 1992; Swedo & Rapoport, 1991)*. Additionally, some practitioners warn that therapies that "uncover" previously unconscious material in OCD patients may run the risk of increasing anxiety and OCD symptoms *(Greist, 1991)*.

In view of this troubled history, it is worth trying to counter the tendency to "throw out the baby [psychodynamic therapy techniques] with the bath water [psychoanalytic understandings of the etiology of the disorder]." Psychodynamic play therapy may prove a helpful adjunctive service when integrated with behavioral and psychopharmacological interventions in the treatment of children with OCD. This possibility has some support in the literature. Adams *(1985)* advocated for an integration of psychodynamic and verbal modalities with behavioral and pharmacological treatments of OCD. March *(1995)* noted that psychodynamic approaches can be effective in treating the low self-esteem and troubled peer relationships that frequently accompany OCD in children and adolescents. Leonard and colleagues *(1991)* asserted that while psychodynamic treatment alone may be ineffective in treating OCD, "it can play an important role by addressing both general and specific issues in the patient's life" *(p. 487)*, including issues of self-esteem, relationships, general outlook, and adherence to treatment regimens. While recognizing the limitations to psychodynamic theory and practice for the treatment of OCD symptoms, there is an argument to be made for their utility in facilitating optimal adjustment of youngsters with OCD.

PSYCHODYNAMIC THEMES

While psychodynamic therapy alone is unlikely to decrease obsessions or compulsive behavior, it can be used to support the child who suffers from OCD *(Leonard et al., 1990)*, and to provide empathy and insight about the impact of the disorder on development and functioning. OCD represents a constellation of symptoms that often hold individualized intrapsychic meaning. A strength of the psychodynamic treatment approach is its capacity to explore the personal meanings and implications of the symptoms for the individual child.

This is not to say that intrapsychic dynamics give rise to OCD symptoms. Rather, it is the experience of the symptoms that inevitably affects children's self-image, view of relationships, and capacity to tolerate affect and modulate intrapsychic conflict. Additionally, OCD symptoms often assume a powerful grip over children, creat-

ing strong resistance to change. A psychodynamic perspective offers both a theoretical model for understanding these issues and a treatment approach for ameliorating the negative impact of the disorder on the individual.

Self-Image and Object Relations

An important aspect of a psychodynamic approach involves awareness of OCD's impact on children's self-image and expectations of how others will perceive and respond to them. Youngsters with OCD often grapple with worries about what their unusual symptoms and behavior mean about them. These worries can contribute to shame, self-doubt, and isolation.

The shame and secrecy commonly associated with OCD interfere with the development of youngsters with the disorder. They can preclude reaching out for parental support or even letting parents know about symptoms. Similarly, OCD can interfere with appropriate peer relationships and social development *(Hollingsworth, Tanguay, Grossman & Pabst, 1980)*. Children may hang back from social interaction in order to keep their obsessions or compulsions secret. In addition, the time and energy spent trying to manage OCD symptoms can detract from the quality of social engagement with other children. For example, one boy with OCD described his outrage when his siblings' behavior (e.g., how they poured cereal in a bowl or arranged toys on a shelf) interfered with his compulsive need to establish and to maintain order.

Affect Modulation and Intrapsychic Conflict

Many youngsters with OCD are quite sensitive and have difficulty tolerating the level of anxiety and intrusiveness of obsessive thoughts engendered by the disorder. In response to this discomfort, children may develop a constricted emotional style or rely on such defenses as projection or reaction formation to help them cope. A psychodynamic approach can aid in assessing the extent to which such defenses are adaptive or maladaptive for a given child. Affect modulation enables children to discharge anxiety, anger, sadness, or other emotions in an adaptive fashion. Through play, therapists can normalize children's feelings and encourage expression of emotions.

A psychodynamic approach also involves understanding the role of intrapsychic conflict in the personality development and functioning of a child with OCD. For example, a youngster may want to be free of symptoms while at the same time wanting to hold onto them because they have become familiar or reassuring. Children may also find that awareness of unacceptable impulses related to obsessive thoughts (e.g., aggressive fantasies) or compulsive behavior (e.g., repeated hand-washing) is in conflict with internalized standards or superego prohibitions that label these impulses as bad, weird, or dangerous. Furthermore, it is possible that given a biological predisposition to developing OCD, a child's particular personality structure contributes to the nature of the specific obsessions or compulsions accompanying the disorder.

Overcoming Resistance to Change

Many researchers have commented on high rates of resistance and recidivism for OCD treatments, despite robust findings to support the efficacy of behavioral and pharmacological interventions *(Bolton, Collins, & Steinberg, 1983)*. Psychodynamic play therapy can provide avenues to explore and to ameliorate feelings and worries that impede adherence to the other treatments. For instance, some youngsters may be scared to give up the internal organizing framework supplied by their system of compulsive behavior, or to relinquish a role their disorder plays in maintaining family dynamics (e.g., keeping parents engaged with the child or with each other).

Play therapy offers a format for understanding children's concerns about the in-

terventions, and provides opportunities for mastery. Just as play therapy can be used to help children prepare for a medical procedure or surgery, it can help them understand the rationale for response-prevention techniques and give them practice in coping with the resultant anxiety. Such preparation in play often enables children to deal more actively and effectively with the stress of actual interventions.

PSYCHODYNAMIC TECHNIQUES

In addition to a theoretical framework for understanding the impact of OCD on children's functioning, a psychodynamic approach also provides specific therapeutic tools and techniques. Play therapy is a powerful vehicle through which youngsters can express their view of themselves, the world, and their struggles. Well-trained therapists can label the themes, feelings, and conflicts dramatized in play. Through this process, children come to feel less alone in their experience, and are empowered by having it put into words. Play therapists can normalize children's experiences or worries and offer support and empathy for their struggles. They may also be able to offer insight or guidance about how to manage particular situations more adaptively.

Displacement

Displacement, a technique in which a therapist describes the experiences of a hypothetical child rather than speaking directly to the experiences of the client child, can allow for less defensive or uncomfortable exploration of pertinent themes. For instance, youngsters who cannot tolerate talking about how repetitive checking behavior impedes their school performance may be captivated by the story of a youngster facing similar struggles. They may be able to elaborate on the imaginary child's worries, shame, and concerns in greater depth and specificity than they could their own dilemmas.

Dramatic play, sand tray play, puppet play, art work, writing stories or books, and discussing movies are all forms of displacement that can facilitate self-expression. For example, in her work with a six-year-old girl with OCD, one of the authors used a technique of collaborative story writing to label fears and worries, prescribe behavioral interventions, and suggest new coping skills through a developmentally familiar and appropriate medium. This helped the girl to feel understood and accepted, as well as to grasp the steps involved in changing her unwanted behavior.

Interpreting Defenses

The interpretation of defenses is a technique often employed in play or talk therapy with children. It helps youngsters understand how one feeling or behavior is being used to defend against another unwanted feeling or impulse, thus permitting greater insight and flexibility. For instance, a therapist can help a child to see that a particular compulsive behavior is helping to ward off anxiety or sadness, and that these could be better dealt with if expressed directly. In addressing defense mechanisms, therapists can help children tolerate a wider range of affects more easily, and show them alternative coping strategies that may be more adaptive.

Transference and Countertransference

An appreciation of transference and countertransference dynamics is a useful tool in treating children with OCD. Children's anticipation of a therapist's response to them may well mirror their experience of themselves or their expectations of others. Using the psychotherapeutic relationship as a window into a child's sense of self and relationships offers a compelling opportunity to work through any misconceptions or unrealistic expectations that may hinder the child's development or connections to others.

CASE STUDY

The case of Annie illustrates the application of psychodynamic theories and tech-

niques to the treatment of a child with thought and behavior patterns consistent with OCD. In Annie's case, the most notable types of compulsive behavior were symptoms of trichotillomania.

Background

Annie was referred to treatment by her pediatrician when she was four years old. Her parents' primary complaint at the time of evaluation was that she was compulsively pulling out and chewing on her hair. This behavior was severe enough to have created a small bald spot at her crown and was attracting the attention of other children and adults. Although her trichotillomania symptoms were the most serious of her obsessive-compulsive types of behavior, Annie also displayed milder symptoms, including several fixed and immutable routines in her day, and traits that her parents described as "perfectionism."

No stressful or traumatic events preceding the onset of this behavior could be identified by her parents. The birth of her first sibling had occurred six months earlier but they did not feel that Annie was having a difficult time accepting her new sister. Aside from the compulsive behavior, her parents were aware of only one other behavioral difficulty—a tendency to occasional aggression at school; her teacher had complained that she sometimes hit other children over the head with stuffed animals.

Annie's parents presented as concerned parents who were anxious about their child's "odd" behavior. Her mother, in particular, expressed many fears that she had somehow raised her daughter poorly and thus contributed to the problems. As the couple explained daily routines and behavioral expectations in the home, it became clear that their tolerance for messiness in the house was low. This was reflected in the therapist's first meeting with Annie; when asked her if she knew why her parents had brought her to therapy, Annie replied, "Because I didn't keep my playroom clean?" While the emphasis on cleanliness was not inappropriate or harsh, it inadvertently reinforced Annie's discomfort with her own sense of "messiness."

From data gathered in the initial evaluation, the therapist (DL) and supervisor (SG-S) felt that Annie would benefit most from a structured behavior modification plan combined with psychodynamically based play therapy. The behavioral treatment would target her trichotillomania symptoms and other compulsive behavior. Concurrent play therapy would seek to overcome her resistance to change, improve her self-concept, deal with her feelings of shame around her compulsions, and increase her tolerance for a range of negative feelings. Techniques included displacement and the interpretation of defenses, resistance, and transference dynamics.

Resistance and Displacement

Annie was inconsistent about acknowledging her symptoms; sometimes she would admit to pulling her hair and other types of compulsive behavior, sometimes she would deny them. A behavior modification plan appropriate to her four-year-old level of understanding was designed. Essentially, the goals were to raise Annie's awareness of her hair pulling and to introduce a competing behavior that would be incompatible with it. For example, she was allowed to pick out a small squishy toy that she could keep in her pocket and squeeze with her hands whenever she felt the urge to pull her hair. In addition, she was awarded points on a sticker chart every time she reported such an urge to her parents. After a few weeks it became clear that Annie was resistant to this plan. The resistance was addressed through play therapy, with displacement offering a nonthreatening technique for discussing Annie's "unspeakable" wish to retain her compulsive behavior and her fear that she would be unable to change if she tried:

In an early session, the therapist brought in a set of animal finger puppets—a squirrel, a weasel, and a skunk. Annie immediately picked up the skunk,

sniffed at it, and announced, "this guy stinks!" She opened the office door and threw him far out into the hallway. The therapist commented that the skunk is so stinky they wouldn't even want him in the room with them. The therapist also wondered aloud how the skunk might be feeling after being cast so far away. Annie suggested he might feel lonely, and the therapist used this to discuss how the skunk probably felt this way quite often; maybe his friends teased him for being so stinky. Asked how the skunk might feel when that happened, Annie at first tried to avoid the question, then finally replied that he might feel "a teeny bit angry." The therapist normalized this anger, remarking that animals often feel angry when other animals make fun of them or want them to be different.

The therapist next suggested that they could work together with the skunk to help him gain control over his stinkyness. Annie strongly rejected this suggestion, insisting that the skunk would remain stinky no matter how hard she and the therapist tried to help him change. The therapist wondered if the skunk kind of liked being stinky, and Annie said that he did.

Thus, through displacement, Annie was able to talk with the therapist about the good parts of compulsions (the comforting role that they serve), the anxiety that results from trying to change familiar behavior, and the resistance that arises at the thought of giving it up.

In subsequent sessions the therapist continued to use the skunk to explore feelings of resistance to change, as well as the rewards of gaining control over undesirable behavior. This displacement technique allowed the therapist to stress the importance of behavioral changes without being too confrontational or threatening Annie's self-esteem. About halfway through treatment, Annie decided that the skunk did not stink quite as badly and no longer needed to be thrown into the hallway. Rather, each week he was tossed into the trashcan, but allowed to remain in the room. Her treatment of the skunk marked a shift in Annie's own adherence to the behavioral plan, and her increased commitment to working toward changes in her compulsive behavior.

Self-Image and Object Relations

Some of Annie's fears and worries around her unwanted behavior were addressed through displacement with the skunk puppet. Related issues began to appear through another theme in the play. A few sessions into the treatment, Annie introduced a story line involving a dollhouse family and their pet cat. Each week, the family rejected the cat for a variety of reasons. Sometimes he made a big mess in the house that upset the family. At other times they just didn't want to be around him. Eventually, other pets came along and took his place, and the family preferred these interesting new pets to the old and messy cat. Through this story, Annie was able to express her fears of being rejected by her family for being imperfect or too messy, and to broach issues of sibling rivalry. This gave the therapist opportunities to counter Annie's distorted beliefs that the birth of her sister represented her parents' wish to replace her with a "better" child. Addressing sibling rivalry issues was a key component of the treatment, as the stress of these unresolved feelings was probably an exacerbating factor in Annie's OCD. Through play with the cat and the dollhouse family, Annie began to accept the idea that a family can love more than one pet (or child). As her anxiety over being replaced or rejected from the family subsided, her ability to focus on changing her compulsive behavior grew. Her aggressive behavior in school also decreased, suggesting that therapy provided her with a place to discharge feelings of anger and jealousy previously manifested in her peer interactions at school.

Shame and the Transference Relationship

With Annie, the use of the skunk and the family cat as displacement objects helped her see that her behavior could be tolerated and would not lead to rejection, even as she and the therapist worked on modifying them. In addition to the puppet and doll play, Annie also used a variety of art supplies in the treatment. She evidently enjoyed using such media as clay and Play-Doh, seeming to revel in the process of

getting dirty and making messes. Suspecting that this kind of behavior was met with rigidity and disapproval at home, the therapist explored what it meant to Annie to make a mess in the therapy hour. At first, they discussed how it could be fun to be messy, and how this was acceptable as long as one abided by the rules. Then, Annie began to test the limits of the therapist's tolerance for her messiness, forcing the establishment of some basic rules to be followed in the office to prevent things from being ruined. Annie clearly resented these rules and displayed her anger by "accidentally" spilling water, smearing clay on the rug, or putting "slime" in the therapist's hair. Her anger at the rules and perception that the therapist was confining her behavior provided a chance to talk about the real and imagined consequences of breaking rules. Most importantly, Annie eventually learned that breaking a rule did not lead to permanent rejection or withdrawal of affection. She also learned that it was possible to express feelings, even if there were certain limits on behavior, as in the following instance:

> Annie was playing with Play Doh and surreptitiously began to pour water over it, a violation of the rule that she could not play with water and Play Doh at the same time. When the therapist asked what she was doing, she vehemently replied, "I am not breaking the rules." The therapist said, "I wonder if you are curious about what I will do when you break the rules—if you wonder whether I will still like you?" Annie nodded, silently. The therapist added, "Some kids wonder what will happen when they break the rules at home—will their parents still love them?" Eagerly, Annie interjected, "Or will their parents throw them in the garbage can?" "Wow," the therapist said, "that sounds like a scary thought, to think about parents doing that!" Backing away from this disclosure of fear, Annie said, "No, it's a silly thought." "Well that's true," the therapist replied, "But sometimes thoughts can be kind of silly and scary at the same time." "Or silly and scary at different times," Annie suggested.

This is one of many instances in which Annie's play indicated an underlying shame about her impulses and behavior, and highlighted her fears that they were so bad that they might cause her parents to stop loving her. Play gave Annie the opportunity to express these feelings, which were otherwise unspeakable for her. It was also important that her feelings of shame about her hair pulling be more directly addressed. During one session Annie began to talk about her "friend" who had a habit of pulling out her hair and chewing on it. This and other instances provided opportunities to talk in displacement mode about how it feels to look different from other children or to have urges to do things that feel out of one's control. As themes of shame arose in the play, the therapist was able to make links to emotions arising from Annie's increasing awareness of compulsions, which was a result of the behavior modification plan. The therapist helped Annie to understand why she should change certain types of behavior, and to focus on the reasons rather than on her feelings of shame or inadequacy about her compulsions.

Affect Tolerance and Modulation

A final focus of the psychodynamic component of Annie's treatment centered on her ability to feel and express a range of emotions, including negative ones. Although some of her difficulty in verbally expressing her feelings was developmentally appropriate, she seemed to struggle with this more than did most children of her age. Her parents were encouraged to help Annie learn to "use her words" when she was feeling angry, sad, or frustrated at home, and to work on sending a clear message that they could tolerate such feelings. In the treatment itself, learning to express feelings arose as a theme in all realms of the play. When Annie resented the rules imposed on "messy" play, the therapist encouraged her to talk about her anger or frustration. The therapist's acceptance of these feelings, and the message that Annie could have them and still maintain the therapist's affection, were critical to her improvement. Acceptance and normalization of her jealousy about the birth of the new

sibling also brought Annie much relief, and appeared to contribute to her success in altering her behavior, both compulsive and aggressive. Besides addressing the expression of feelings that arose spontaneously in play during treatment, the therapist introduced other techniques specific to this goal. One week, Annie made up an "angry" dance to show her feelings, and she often drew pictures related to feelings addressed in the sessions. While expression of feelings still needed work by Annie and her parents after treatment ended, significant progress in this area was achieved through the play therapy techniques used in the treatment.

CONCLUSIONS

The simple behavioral plan aimed at decreasing Annie's compulsive behavior appeared to be successful. Although Annie did not always comply with the instruction to report her urges to her parents, heightening her awareness of the urges and encouraging her to engage in competing behavior helped reduce her hair-pulling. Through the play themes and the therapist's interpretations of her conflicts, wishes, and behavior, Annie seemed to develop an increased tolerance for her own "imperfections." As a result, her initially overwhelming fear of being cast out of her family for her messiness and bad habits appeared to subside.

The therapist encouraged her parents to give Annie her own space and her own individual time with them. This facilitated a reduction in Annie's hostility toward her sister, and in her aggressive behavior at school.

Most importantly, the psychodynamic play therapy work was a significant adjunct to the behavioral techniques aimed at ending Annie's hair pulling and other compulsive behavior. After 8–10 sessions, her hair pulling had decreased to the point where her hair growth appeared normal and her parents were finding no evidence of pulled hairs at home. Treatment was terminated after 22 sessions. In the final session, the therapist inquired about the skunk, who had been thrown into the trash can, as usual. Annie thought for a moment and then announced that the skunk had taken a bath and smelled okay. She decided it would be all right if he came out of the trashcan and joined her and the therapist as they talked about the progress Annie had made.

The case of Annie illustrates the ways in which psychodynamic play therapy can be integrated successfully with behavioral techniques. Without the behavioral response prevention and family interventions, it is doubtful whether the trichotillomania symptoms would have decreased. However, without the opportunities that play therapy provided for Annie to feel understood and to develop a sense of mastery regarding her disorder and treatment, it is doubtful that Annie would have complied with the other interventions or made such a positive overall adjustment. The integration of play therapy with behavioral techniques allowed for a greater understanding of the child's experience and provided her with a treatment approach that she could more easily embrace. These, in their turn, led ultimately to greater treatment success and more positive child adjustment.

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