Treating Traumatized Children through Puppet Play Therapy

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Abstract

Play therapy and Adlerian psychology have much in common. Both are encouraging approaches based on the meaning of human actions and focus on human strengths. This paper explores the development and application of puppet play therapy, while including elements of Adlerian play therapy. Informed by Adlerian psychology and Adlerian play therapies, recommendations are made for using puppet play therapy with the specialized population of traumatized children.
Treating Traumatized Children through Puppet Play Therapy

When a child plays, it is a natural, non-threatening, and straightforward activity for the child to express emotions, concerns, and innermost thoughts of which he or she may not even be conscious or able to verbalize due to the child’s developmental stage. Erikson (1964) asserted that “to ‘play it out’ is the most natural self-healing measure childhood affords” (p. 222). Play as a therapeutic tool can be beneficial for many specialized populations, specifically traumatized children. Felitti, Anda, Nordenberg, Williamson, Spitz, Koss, and Marks (1998) maintain that the prevalence of childhood traumatic events is common. Therefore, the necessity of a play-based therapy to aid these children in the processing and understanding of the event(s) is essential to healthy coping, overcoming the trauma, and continuing forward as psychologically healthy children. This paper is intended for any mental health practitioner who currently or plans to work with children in the future, regardless of the presenting problem. It is essential that a mental health clinician working with children know this information to adequately address any trauma concerns that may arise. The mental health practitioner must have adequate skills to assist the child in working through the event in a safe and non-threatening manner and through an avenue which the child understands. Play therapy is an excellent therapeutic avenue when working with children.

This paper will discuss the play therapy of puppet play when working with physically, emotionally, and sexually traumatized children. It will address the research and themes involved in each type of trauma. A brief play therapy history will be discussed including the researched benefits of play therapy. Adlerian play therapy will also be expanded upon, including its history and Adlerian play therapy concepts. The specific therapeutic technique of puppet play therapy will also be discussed, including its history and how a mental health practitioner would go about
carrying it out with a child client. Finally, the age groups of 3 to 11 year old children will be reviewed with respect to the effectiveness of puppet play therapy within varying age groups based on the developmental stage of the child.

There are assumptions and limitations within this paper that require addressing. The assumptions include that traumatized children will need psychotherapy with a mental health practitioner and that puppet play will be beneficial with all children in the appropriate age groups. This is not necessarily true despite the research that supports its usefulness. Some children may be able to adequately cope with the assistance of family or another supportive adult. Additionally, children move through the stages of development at varying rates, so it is always important for the behavioral health practitioner to be cognizant of the uniqueness and individuality of each client’s current developmental stage and ability to process and cope with a trauma. There is also a very important limitation within this paper that must be addressed to ensure awareness. It is that the writer was unable to research all types of play therapy and techniques available to children in order to determine if puppet play therapy is superior to other therapeutic avenues available for the age group of 3 to 11 year old children. With all available therapies that have been modified to include the child population, as well as therapeutic techniques specifically intended for children, this would have been an impossible task to achieve. It is important for the reader to be aware of these noted assumptions and limitations when reviewing this paper.

**Childhood Trauma**

**Physical Trauma**

**Definition and prevalence.** Trauma that occurs in childhood can have long lasting emotional and psychological consequences. Crittenden (1999) broadly defines a childhood
traumatic experience as any life event that threatens a child’s health. This threat can be physical or emotional, real or interpreted, to self or to an attachment figure. According to Felitti et al (1998), the prevalence of childhood traumatic events is common. Specifically, Giardino (2011) documented that of the 905,000 children reported as maltreated in 2006 in the United States, 16% were categorized as being physically traumatized. With such a high incidence of reported cases of physical trauma to children, it is wise and responsible for mental health practitioners to become aware of research to best aid children who develop emotional or psychological repercussions as a result of physical trauma.

Physically traumatized children may develop physical and psychological symptoms. A common physical symptom that can be easily identified is speech impediments of verbal communication disabilities (Piperno, Di Biasi, & Levi, 2007). In addition to the regression of verbal skills, a traumatized child may also be at risk for developing mental health and behavioral symptoms. This may be the result of an inability to accurately process the event due to lack of emotional and psychological development of comprehension and interpretation. Research by Edgar-Bailey and Kress (2010) found that traumatized children are often inhibited from progressing to a state of mental health due to the symptoms and disturbing images remembered from the trauma. It is important that mental health practitioners be cognizant of physical symptoms a child may exhibit as well as the emotional and psychological outcomes.

**Research and themes.** Physically traumatized children have many common mental health themes that may need attention. Common internalized themes of traumatized children include self-blame, aggressive anger, guilt, physical aggression, academic problems, low self-esteem, bed-wetting, shortened attention span, an inability to control anger, lowered self-esteem (Kot, Landreth, & Giordano, 1998), and a sense of loss of control (Edgar-Bailey & Kress, 2010).
Because the trauma can be very confusing and a child may not have the developmental ability to attach meaning to the trauma, a child may develop conflicted thoughts and feelings. A child may develop a distrust of persons of authority for being unable to keep the child safe as a result of a traumatic situation. When a child is unable to cope with trauma in a healthy manner, a child may detach emotions. This “is detrimental for the child’s future relationships, and connecting with their emotions is essential to their healing” (Edgar-Bailey & Kress, 2010). Finally, a mental health practitioner must remain mindful of the theme of reenactment of the physical trauma.

According to Kot et al. (1998), physically traumatized children often imitate the violent or physical behavior they have witnessed, remain reluctant to be socially interactive, and are less able to utilize adaptive coping skills when needed. A physically traumatized child may exhibit excess energy that is observed to be rage-filled. A physically traumatized child may appear to an observer as defeated and/or hypervigilant. As a mental health practitioner, it is important to remember that this population must be carefully observed and their behavior taken into context according to their experiences. The powerful information regarding the repercussions of physical trauma should alert mental health practitioners that traumatized children are a special population with a unique set of themes. The mental health practitioner must work effectively and efficiently to address the theme or themes with which a child presents and assist the child to reach a healthier state of mental health through coping and understanding of the traumatic situation.

Physically traumatized children may present to a therapist’s office exhibiting many different types of concerns including emotional distress, psychological distress, and/or behavioral concerns. According to Koverla, Pound, Heger and Lytle (1993), a mental health practitioner must complete a comprehensive assessment in the areas of cognition, affect,
morality, interpersonal relationships, sexual development, and physical development in order to gauge the impact of the trauma. Recommendations are made in this paper regarding the combination of Adlerian play therapy with puppet play to effectively treat emotionally traumatized children with an array of presenting concerns.

Finally, it is important for a mental health practitioner working with a physically traumatized child to work diligently to establish a healthy therapeutic relationship. The goal of the therapeutic process is to assist the child in reaching an optimal state of mental health with as few psychological symptoms and behavioral issues as possible. According to Edgar-Bailley and Kress (2010), “the ability of a child to trust an adult enough to express painful emotions is a key component to breaking down feelings of isolation, mistrust and cynicism” (p. 163). The establishment of a good relationship between the client and therapist is required for all populations, and the first step in establishing that relationship as a mental health professional is carefully working to establish a healthy and trusting relationship with the traumatized child. While physically traumatized children present a challenge for the mental health practitioner, emotionally traumatized children can present as equally challenging.

**Emotional Trauma**

**Definition and prevalence.** Emotional trauma in children, according to Hanney and Kozlowska (2002), is defined as “life events that threaten a child’s physical or emotional health or safety” (p. 37). An example of emotional trauma is children who witness abuse of another person: mother, father, sibling, friend, etc. Emotional trauma also includes “verbal abuse, neglect, humiliation, relationship breakup or the death of a loved one” (Cohen, 2007, n. p.). According to Giardino (2011), the prevalence of childhood emotional abuse in the United States is 6.6% of the 905,000 reported cases. For a mental health practitioner, it is especially important
to be alert to emotional trauma because it may not be as obvious as the visual physical signs seen on a physically traumatized child.

**Research and themes.** Within the population of emotionally traumatized children, themes emerge. Common themes discussed in the research are “low self-esteem, lack of impulse control, short attention span, an inability to control anger, physical aggression and verbal abuse or passivity and withdrawal, and possibly pseudo-maturity along with behavioral and academic problems” (Kot et al., 1998, p. 18). Notably, a theme this population often presents is a sense of a loss of control (Edgar-Bailey & Kress, 2010). This theme is due to the child’s inability to change the emotionally traumatizing event. It may also be due to the child’s inability to psychologically comprehend the event due to a primitive stage of development.

Another common theme within this population is distrust of adults (Edgar-Bailey & Kress, 2010). This may be a reflection of the child’s assumption that if an authority figure is unable to protect him or her in an emotionally vulnerable situation, then the authority figure does not deserve the trust that the child may have to offer in any other situation.

Another common theme within this population is that emotionally traumatized children are less able to utilize appropriate coping skills when presented with other stressful situations (Kot et al., 1998). And finally, Kot et al. (1998) also indicated that emotionally traumatized children had less social interaction than their non-traumatized peers. Aware of these themes, mental health practitioners must find creative and alternative ways to work with this population to be effective and beneficial for the child and her or her needs.

Much like working with all populations of clients, the relationship between the therapist and the client is of primary importance. According to Edgar-Bailley and Kress (2010), “the ability of a child to trust an adult enough to express painful emotions is a key component to
breaking down feelings of isolation, mistrust and cynicism” (p. 163). The therapist must be validating, kind, and trustworthy. Before true therapeutic work can be done on behalf of the child, this relationship must have solid footings since the information shared by the child through direct or indirect avenues may be very painful for the child. Much like within the physically traumatized population of children, the emotionally traumatized child may also develop speech impediments or communication deficits due to the trauma (Piperno, Di Biasi, & Levi G., 2007). Therefore, it is important for the therapist to remain cognizant and patient despite these disabilities on behalf of the child. As with emotional trauma, sexual trauma in childhood also has psychological and behavioral repercussions that a mental health practitioner must be informed about prior to working with this specialized population.

**Sexual Trauma**

**Definition and prevalence.** According to the Sexual Trauma and Counseling Center (2011), the definition of sexual trauma is “forcible sodomy, sexual assault with an object, and forcible fondling. All of these acts are committed without consent and with force” (n. p.). The prevalence of sexual trauma is very difficult to estimate due to it being extremely underreported (Sadowski & Loesch, 1993). The statistics concluded by researchers indicate that the rate of sexual trauma in childhood varies from 1% to 35% of children experiencing some form of sexual trauma before reaching the age of 18, while professionals working in the field estimate the rates from 8% to 20% (Darkness to Light, 2010). According to Giardano (2011), the prevalence of sexually traumatized children is approximately 8.8% of the 905,000 cases reported in 2006 in the United States. Johnston (1997) notes in the research that there has been a “dramatic increase in the incidence of sexual abuse of the last decade” (p. 101). Informed with these staggering numbers and the knowledge that sexual abuse often goes unreported to the appropriate
authorities, a mental health practitioner is responsible to learn about this specialized and fragile population prior to beginning the therapeutic process with a sexually traumatized client.

**Research and themes.** Children who are victims of sexual trauma exhibit similar themes to physically and emotionally traumatized children as noted by the research. According to Namka (1995), sexually traumatized children exhibited internal anger, unworthy feelings, and helplessness. Namka’s research also warned that children who have been sexually traumatized may develop unhealthy coping mechanisms to keep themselves safe. These unhealthy coping mechanisms in adulthood may exhibit as dysfunctional behavior, personality disorders, or traits and/or addictions.

In childhood, the mental health practitioner must work with themes the child displays including suppression, flashback behaviors, repetitive or reenactment of the abuse, loss of trust in others, despair, shame, and a heightened degree of arousal and self-consciousness. It is important for the mental health practitioner to be aware of these themes prior to working with a sexually traumatized child in a therapeutic relationship.

When working with sexually traumatized children, it is important for the mental health practitioner to not only be aware of the themes a child in this population may present, but also be aware of what types of therapeutic tools will be beneficial and effective. After all, verbal communication may not be the best avenue for obtaining information from this population. Piperno et al. (2007) asserted that within the sexually traumatized child population, speech impediments may develop as a result of the trauma. Grubbs (1994) suggested introducing the child to a medium that may help resolve his or her pain and conflict in non-verbal ways since it may be “extremely difficult for children to acknowledge, let alone verbalize” (Grubbs, 1994, p. 195). Johnston’s (1997) research concluded the following:
Therapists interacting with sexually abused children, in particular, have been forced to move beyond verbal communication and explore alternate forms of therapy which are compatible with the child’s level of cognitive and emotional development. Because the child’s preferred style of communication is that of active play and visual imagery, therapists are more likely to create a successful therapeutic relationship and witness more significant change in the client’s positive growth through the use of applied techniques. (pp. 111-112)

Childhood trauma research indicates the most productive and effective avenue for this population is through play therapy techniques. Following is an overview of play therapy, its history, and its benefits.

Play Therapy

History

The history of play therapy is rich and dates back more than 75 years (Schnoebelen & Smith, 2008). According to Porter, Hernandez-Reif, and Jessee (2009), “play therapy is an interpersonal process whereby through play a trained therapist helps children with behavioral, emotional and traumatic problems, and facilitates children’s learning of coping skills” (p. 1025). Play therapy has a history that has made it a well known and a popular treatment avenue chosen by mental health practitioners. Early psychoanalysts (Sigmund Freud, Anna Freud, and Melanie Klien) were the first to develop play therapy theories when working with children rather than using free association as a therapeutic tool. After these theorists laid the groundwork beginning in 1909, Virginia Axeline developed a school of play therapy in 1947 that further elaborated on the theory. Finally, developmentalist Jean Piaget elaborated on the use of play in therapy and emphasized the importance of play within cognitive development (Porter et al., 2009). Play therapy history continued to develop throughout the years due to the groundwork from these
early pioneers.

**Play Therapy Summary**

Currently, play therapy has expanded to include many different approaches, depending on the background of the practitioner. Porter et al. (2009) warn that play therapists must consider the contextual factors of the client and the expected outcome of the therapeutic process before choosing the specific approach the practitioner will use. Approaches expanded upon by Porter et al. (2009) include client-centered play therapy, non-directive play therapy, cognitive-behavioral play therapy, and Adlerian play therapy.

While children play, an untrained mental health practitioner may interpret the child’s behavior as ambiguous or meaningless when in fact the themes and information being expressed are full of meaning and awaiting interpretation by a trained professional. To become a registered play therapist, a practitioner needs a master’s degree or higher from an accredited university and more than 150 hours of specialized training followed by clinical experience and supervision (Porter et al., 2009). The basic skills learned by the mental health practitioner, according to Porter et al (2009) include:

- Non-verbal communication, such as leaning forward to appear interested, seeming comfortable and using appropriate tone of voice as well as using short responses that the child’s interest is not lost. Basic verbal skills’ training includes: (1) Learning to respond to the child, and remembering that children have limited language ability and tracking behaviors by using words to state the behavior of the child… (2) Reflecting content or restating what the child is saying. (3) Reflecting feeling or responding verbally to a child’s expression of emotions…(4) Facilitating decision-making, such as providing choices and allowing children to make decisions on their own… (5) Enhancing patients-
therapists relationships by building self-esteem and self-worth, as well as encouraging children to love themselves. (pp. 1029-1030)

While having these skills is essential for mental health practitioners, it is also important for the practitioner to have the skills to accurately interpret a child’s play.

A play therapist is able to obtain a plethora of information about a child through the interpretation of the child’s play while in the therapeutic setting. O’Connor (2002) recommended a six step process for efficient interpretation. In the first step, the therapist builds a hypothesis based on the child’s presenting problem and symptoms. Next, the therapist develops a treatment plan in conjunction with the child emphasizing ways that the treatment plan will improve the child’s life. It is at this point that it is very important for the therapist to explain that this improvement takes effort on behalf of the child. The third step recommended by O’Connor (2002) is to “develop a list of interpretations that will be used to show the child a different way of viewing his/her problems” (p. 1030). Next, the therapist begins interventions during play followed by aiding the child to learn new techniques to the problems presented. And finally, the therapist works with the child to process how some outcomes can be generalized and used in other situations for improved mental health and functioning (O’Connor, 2002). A magnitude of information can be learned about a child through the observation of play. The benefits are vast.

Researched Benefits

According to Piaget (1962), a child under the age of 10 likely does not have the abstract reasoning and language skills to accurately express his or her thoughts or feelings verbally. A mental health practitioner is able to access play therapy as a tool to obtain information from a child that may not be developmentally available or, due to a trauma, repressed. According to
Kot et al. (1998), “play bridges the gap between concrete experience and abstract thought” (p. 20). Playing is a very natural and non-threatening form of communication for children (Kottman, 2001). Therefore, using play as a therapeutic tool in a clinical setting can be very beneficial for the mental health practitioner and child to begin forming a therapeutic relationship through age-appropriate communication. Additionally, play can be used as a therapeutic tool to learn about the client. According to Irwin (1985), play “offers one of the best ways of learning about the psychic reality of the child, and his/her worries and wishes” (p. 389). While play can be an avenue to learn about a child and address mental health concerns, it can also be an effective tool to address very serious mental health concerns.

Play offers children a therapeutic avenue to address very serious and disturbing concerns. According to Mulherin (2001), stress and trauma can be confronted and mastered through the active process of play. Green et al. (2010) echo that sentiment by asserting that play allows children to master a traumatic situation through the safe environment of a mental health practitioner’s office. Furthermore, through play therapy, the child is allotted the freedom to choose when he or she confronts an issue. Play is an avenue for “children to practice corrective, empowering actions and release blocked energy related to a sense of powerlessness and anxiety” (Green et al., 2010, p. 98). The ability to organize information and make sense of past events through play can be very empowering for a child who feels he or she has lost control due to symptoms, unexplainable behaviors, and experiences out of his or her control. Kot et al. (1998) claims, “for healthy growth and development, it is essential that children are free to transform an event and change their role from one of passivity into a role of active investigator and controller” (p. 21). Adlerian play therapy is a specific type of play therapy that addresses how mental health concerns can be addressed through the principals of Adlerian therapy.
Adlerian Play Therapy

History

The history of Adlerian play therapy is relatively recent compared to Individual Adlerian Psychotherapy. While Adler included children and families in his therapeutic works, and Dreikurs and Soltz (1964) introduced the four mistaken goals of misbehavior in children, none really addressed how play therapy can be used as an avenue for addressing mistaken beliefs, behavioral issues, or family constellation concerns. The basic concepts of Adlerian play therapy have been laid out by Kottman (1992, 1993, 1995, 1995), Kottman and Warlick (1989, 1990) and Lew and Bettner (1996, 1998). The following is an overview of how Adlerian play therapy addresses the basics of Adlerian psychology.

Overview of Adlerian Play Therapy Concepts

Adlerian play therapy and Adlerian psychology have many parallels that apply both to the adult population and have been modified to be applied to the child population. Much like Adlerian psychology, the basis of the belief of humans is similar when applied to Adlerian play therapy. The basis of Adlerian play therapy is the belief that humans are socially embedded, have purpose and meaning for their behavior, have innate strengths and are creative beings (Kottman, 2001).

Adlerian theorists believe that a person’s lifestyle is not fully formed until the age of 8 years old. According to Kottman (2001), “Adlerian play therapists believe that the therapeutic powers of play will facilitate the process of working with children by creating a bond between the therapist and the client based on shared fun” (p. 2). The former part of that assertion by Kottman (2001) is similar to the belief that when Adlerian therapists work with clients, the relationship is extremely important as the foundation for the therapeutic process. Through the
use of encouragement throughout the therapeutic process, Adlerian play therapy is carried out. There are many parallels between Adlerian play therapy and Adlerian psychology, and the four phases of the therapeutic process are similar as well.

The role of the therapist in Adlerian play therapy is similar to that of the therapist in Adlerian psychotherapy that is often used with adults. The therapist is an equal to the client and works to partner and encourage the client to make appropriate changes through the therapeutic process. The therapist is nondirective and allows the client to take the lead and empower himself or herself (Kottman, 2001). The process of Adlerian play therapy is similar to that of Adlerian psychotherapy where the therapeutic process travels through four distinct phases of building an equal relationship with the client, exploring the client’s lifestyle, assisting the client to gain insight into his or her lifestyle, and reorienting and reeducating the client (Kottman & Stiles, 1999). Specifically, the therapist uses toys and play to obtain information about the child’s lifestyle, family atmosphere, family constellation, goals of the child’s behavior, and early recollections. Information from parents and teachers can be used as collateral information. According to Kottman and Stiles (1999), play therapy offers the therapist a tool to “redirect [mistaken] goals, change faulty beliefs children have about themselves, and develop their social interest” (p. 155). Therefore, while the concepts of Adlerian play therapy often used with children and Adlerian therapy often used with adults are very similar, the use of play and toys is specific to Adlerian play therapy.

**Puppet Play**

**History**

The history of puppet play is ambiguous yet rich. To begin, the history of puppet play therapy is addressed according to research by Burneikaite (2009). Burneikaite (2009) asserted
that puppet play therapy began early, and that “even in ancient Greece and in many other oldest cultures of the world, puppets were not only used for esthetical purposes” (p. 112). Children have played with puppets throughout all times in history, but the concept of puppet play therapy is current and growing. Neuropathologist Malcolm Rait from Wales is credited to have first identified the therapeutic usefulness of puppet play in the beginning of the 20th century. Specifically, he used “puppet and puppet performances as a preventative method of healing that helps to overcome children’s neurosis in 1926” (Burneikaite, 2009, p. 114). The theory of this simple method of healing traveled quickly to other countries including the United States, Great Britain, Germany, the Netherlands, and Russia. In Russia, the research focused on puppet plays to “help children overcome stammer and to recover from various neurotic stresses using puppets” (Burneikaite, 2009, p. 114) while addressing concerns of movement disability. While Burneikaite (2009) produced strong research regarding the history of puppet play therapy, additional research documents the recent use of puppet play therapy.

Additional researchers have done historical investigations on puppet play therapy. According to Carter and Mason (1998), “the first documented use of puppets in counseling settings is credited to Woltmann (1940) who helped hospitalized children cope with illness and separation from parents” (p. 1). Carter and Mason (1998) continue explaining the history of puppet play therapy into schools to address children’s interpersonal skills. Gil (1994) and Irwin (1993) published research indicating the benefits of using puppets to conduct assessment interviews with children in an effort to obtain information in an age-appropriate manner. Finally, Mason and Carter (1998) stated that, “counselors use puppets to help identify and deal with emotions that are troublesome for children…” (p. 4) and the use of puppet play therapy teaches children to “learn to trust their emotions again” (Mason & Carter, 1998, p. 4). This additional
history of puppet play therapy is beneficial knowledge. Additionally, the benefits of puppet play therapy are beneficial knowledge for a mental health practitioner who may want to employ this technique in the therapeutic setting.

The benefits of puppet play therapy are well documented. According to Carter and Mason (1998), puppets are “easy to manipulate and can symbolize a variety of things” (p. 2), allowing a child to be creative with what he or she chooses to express. Axline (1947) and Webb (1991) noted that puppets were easy for children to identify with in regards to projecting their own feelings and concerns. They also noted that children felt safe acting out new and different behaviors with the puppets. This can lead to therapeutic healing through depersonalization of painful feelings and objective sharing. Mason and Carter (1998) suggested additional advantages to puppet play therapy as puppet play is a safe and non-threatening form of communication between the child and mental health practitioner. Research by Jewel (1989) asserted that puppet play, in general, offers the benefits of improving communication and language skills; allows the child to overcome emotional and physical isolations; offers an avenue for building self-esteem and encouraging emotional release; allows for decision-making and, therefore, empowerment, and allows for a form of physical therapy through the use of hands, arms, and fingers to manipulate the puppet.

**Technique**

The technique of puppet play therapy is broad. Below is a brief summary of the research on how to carry out puppet play therapy, from choosing the puppets to carrying out puppet play therapy as the therapist. First, it is important to become aware of the multiple types of puppets that can be employed through the puppet play therapy process. According to Carter and Mason (1998):
Commercially made puppets come in four basic formats: (1) hand puppets, (2) marionettes, (3) Muppets, and (4) ventriloquist’s dummies. Hand puppets fit over the hand and use the thumb to move the bottom jaw. Marionettes are operated by pulling strings and rods held together with devices in the puppeteer’s hands. Some marionettes may require more than one puppeteer. Crosses between marionettes and hand puppets are what have been popularly known as ‘Muppets’. One or two Muppeteers operate the mouth in a manner similar to hand puppets while the extremities are operated by strings and rods like marionettes. Finally there is the most realistic type of puppet, the so-called ventriloquist’s dummy. The puppeteer operates the dummy by placing his or her hand inside the dummy and manipulating the puppet’s jaws, arms and legs by strings and rods.

(p. 4)

The type of puppet also influences the type of stage on which the puppet play will take place. Marionettes and Muppets may require a stage to conceal the puppeteer while hand puppets may or may not need a stage, depending on the performer’s preference. The knowledge of types of puppets is important to consider prior to beginning this avenue as a therapeutic process with children.

This research focuses specifically on the use of hand puppets as the puppet play therapy tool. This is because hand puppets are the simplest of all puppets introduced by Carter and Mason (1998) to manipulate and replace in the clinical setting. Carter and Mason (1998) note that “hand puppets are the least expensive, while the others may run into hundreds of dollars” (p. 4) to have in the office. The feasibility of hand puppets makes them the most logical choice for use in the therapeutic setting by a mental health practitioner.

The research identifies the amount and type of hand puppets that would be
therapeutically useful in a clinical setting when working with children. First to be discussed is research by Carter and Mason (1998), followed by research by Irwin (1991) and Bromfield (1995). Carter and Mason (1998) suggest that 15 to 20 is the optimal amount of puppets to have children choose from in a therapeutic setting. Specifically, those puppets chosen by the mental health practitioner “should represent a range of affect such as aggression, friendship and neutrality” (p. 7). Irwin (1991) suggests that puppets should represent realistic family groups and be mindful of culture. Puppets of familiar occupations (i.e. doctor, teacher, farmer) are also useful in addition to symbolic puppets (i.e. a witch, a superhero) and wild and tame animals (i.e. lions, kittens, dogs). The chosen puppets should be easy to use by a child’s hand, also fit an adult’s hand for co-play, be soft to encourage use, easily washable to prevent the spread of germs, and “not carry universal symbolism” (Carter & Mason, 1998, p. 7) in order to encourage imagination and the application of the child’s own symbolism and metaphoric value. Bromfield (1995) also published research on the most appropriate types of puppets to have in a therapeutic setting.

The research published by Bromfield (1995) is related to the information published by Carter and Mason (1998). Bromfield (1995) cautioned mental health practitioners not have too many puppets as this can overwhelm children. Bromfield (1995) also noted that “puppets that are too large or small, inflexible or uncomfortable are less used” (p. 439) in the therapeutic setting by child client. Therefore, he encouraged appropriate sized puppets that are flexible and soft. He also noted that “physically rigid puppets limit emotional display” (p. 440) so may not be as useful as less rigid puppets when clients use them to address emotional concerns through their chosen puppet play. Bromfield (1995) summarized that “puppets that are manipulative, visually and texturally appealing, somewhat ambiguous and sufficiently sturdy enhance symbolic play”
These specific types of puppets, along with those suggested by Carter and Mason (1998) and Irwin (1991), are most beneficial as they represent a large range of characters children may find useful when expressing emotions, concerns, or metaphors through play.

The role of the therapist within puppet play therapy is one of a facilitator of fun through a highly therapeutic process. It is important for a therapist to note that within puppet play therapy, the practitioner does not need to have exquisite talent of puppetry and “puppetry requires no special training” (Carter & Mason, 1998, p. 8). The mental health practitioner merely needs to be willing to play, experiment, and be flexible with the use of the puppets to how the child may want the play to proceed. A practitioner must need to be feel comfortable partaking in child-like activities and become transparent through the puppet play process. For example, the mental health practitioner may find that sitting on the floor with the child is more beneficial than staying in a chair to partake in the puppet play activities. A mental health practitioner must be prepared to speak directly to the puppet when the child’s puppet addresses the mental health practitioner. Children may take this as an unintentional opportunity to interpret the genuine response of the practitioner. By having the courage to be real and fun may be just what a child needs to feel comfortable in a therapy setting or begin to form a healthy relationship with a mental health practitioner.

There are general instructions to therapists who wish to employ puppet play therapy in the therapeutic setting. Carter and Mason (1998) offer instructions to therapists that state that, “a major point to remember when using puppets is to keep the puppet moving, not staring into space. It is important that the movements mimic human-like movements” (p. 8). They further explain that when the puppet play is complete, it is important for the mental health practitioner to be mindful of how this metaphoric and symbolic toy is stored while children are able to see it.
Carter and Mason (1998) suggest that the therapist “should place hand puppets on a stand beside them” (p. 9) to show proper care and respect for such a therapeutic toy for a child. After all, these toys are not only useful to the client but also the therapist who is able to gain invaluable information from the puppet plays and have a simple avenue to begin establishing trust and rapport with a client.

Research supports the concept that the use of puppets in play therapy is useful and beneficial with children who need the support of a safe environment and safe avenue for expression. According to Bromfield (1995), “puppets offer physical and psychological safety that, in turn, invites greater self expression” (p. 435). The puppets are a safe avenue for communication because a child is aware that he or she “cannot be assaulted or abandoned by a puppet” (Bromfield, 1995, p. 436). In addition to the safety that a puppet has to offer, puppets are also a natural avenue by which children can play out conflicts, whether those conflicts be with peers or family. As concrete objects, puppets allow the child physical action and non-verbal abilities that may not be offered through verbal communication due to disabilities or developmental stage of the child.

The outcome of the benefits provided by puppet play therapy is summarized by Bromfield (1995),

Beyond making the child feel better, emotional relief can lessen stress-related body symptoms, delinquent acting out, and other residue of overwhelming tension. A temporary discharge of anxiety can also make the child more accessible to education, reassurance or problem-solving that, in turn, alleviates the source of the distress or remedy a life problem. Puppet can help child patients manager their relationship with their therapist. (p. 439)
The research also noted that “what patients spontaneously offer usually proves more valuable than what we forcibly extract” (Bromfield, 1995, p. 442). Knowing the outcome of such a non-intrusive form of therapy is beneficial for mental health practitioners to gauge whether or not this technique will be useful with clients.

Additionally, puppet play therapy allows for the child to interpret the puppet however he or she wants through ambiguity and versatility of the puppet. A puppet may allow a child to depersonalize an experience because the puppet is an animal versus a human. Much like a mask on the face, the puppet as a “hand costume can serve to create a sense of disguise” (p. 438), therefore encouraging depersonalization and a greater likelihood of a child expressing serious or hard-to-address concerns. A child may interpret a puppet as supportive. He or she “may feel that the puppet holds” (Bromfield, 1995, p. 438) him or her, resulting in more openness or comfort for a child. Puppets are available for children to do anything that they would like from hugging, kissing, hitting, abandoning, and self-soothing due to their versatility. While puppets can be used in an infinite amount of ways, the research indicates that the benefits continue beyond ambiguity and versatility.

While the benefits of puppet play therapy are duly noted, it is important for the mental health practitioner to remain cognizant of some concerns that may arise through the use of puppet play therapy. It is very important for the practitioner to be mindful in deciphering the meanings of puppet play, as each puppet play can carry with it several meanings. Bromfield (1995) specifically warned that, “wild analysis of puppet play is of little value, and can cause harm” (p. 443). As a responsible mental health practitioner, it is always important to check hunches with clients to verify their reliability.

Another warning that a mental health practitioner must remain cognizant about in the
therapeutic process of puppet play therapy is the boundary setting and anxiety assessment that may need to be done with a child. If a child’s play is becoming too intense or dangerous, boundary setting may be necessary if this was not addressed earlier in the therapeutic process. If there is a concern for the child’s safety or if the child is directing inappropriate behavior toward the mental health practitioner, then the practitioner must draw healthy boundaries and redirect the child to more healthy behaviors to ensure safety and respect within the setting (Bromfield, 1995). Additionally, puppet play therapy may provoke anxiety in some children. It is important for the mental health practitioner to continuously gauge this anxiety as “puppet play does not guarantee psychological security” (Bromfield, 1995, p. 443) despite its general safety and distancing ability.

**Effectiveness within Populations**

**Ages.**

**Ages 3 to 5.** Children in different age groups respond to puppet play in varying ways. It is more effective with some age group populations. The research offers findings regarding the use of a play therapy with children, such as the research by Kottman and Warlick (1989) that stated, “since children use play to express feelings, explore relationships and explore themselves, play is the logical medium through which to communicate with children who are experiencing some type of difficulty in their lives” (p. 433). Kottman and Warlick (1989) also noted, “young children have not yet completely mastered the abstract symbols and concepts necessary to verbal communication and may have insufficient experience in the use of language to adequately express their thoughts and feelings” (p. 433). Specific research is necessary to determine ages with which puppet play can apply in the therapeutic setting.
Human development has been vastly studied for many years. According to founder of the cognitive-developmental theory, Jean Piaget, children aged 2 to 7 years “learn to think---to use symbols and internal images—but their thinking is unsystemic and illogical. It is very different from that of adults” (Crain, 2005, p. 115). More recent research presented by Green et al. (2010) contends that “the development of the human brain early in life is complex and dependent upon generic information and external stimulation” (p. 96). The brain development at the age of 3 is rapid, but the right hemisphere is dominant until the age of 3. The right hemisphere of the brain controls visiospatial development. After the age of 3, a child’s brain begins to further develop the left hemisphere. This is responsible for language and logic (Green et al., 2010). The classic research by Piaget is only enhanced by further investigations in the area of childhood cognitive development.

Further research into the area of childhood development revealed additional information regarding specific development happening in the age group of 3 to 5 year olds. It is within this age range that children develop “the ability to talk about feelings, emotions, and other internal states” (Hanney & Kozlowska, 2002, p. 39). At the age of 28 months, children begin to remember and verbalize events as they happen as well as understand time (Hanney & Kozlowska, 2002). An observer may see that “between ages 2-7, cognitive development is characterized by children beginning to be able to use symbols such as symbolic play and imitation, drawing or graphic imagery, mental images, and language to represent their experience, images of others and of events” (Hanney & Kozlowska, 2002, p. 39). With a firm understanding of development for this age group now in place, one is able to address the effectiveness of puppet play with traumatized children in this age group.
The ability to access puppet play in this age group is important. If a child is able to physically manipulate a puppet, this avenue for therapeutic intervention is accessible. According to Hewitt (1998), it is at the age of 3 to 4 years of age that a child is able to first represent oneself with a picture, drawing, or doll. Hanney and Kozlowska (2002) warned that “pre-schoolers have difficulty with complex concepts” (p. 39), so the implication is to keep instructions to a child of this age group simple and straightforward. It is also important to note that many children, when anxious, decrease or completely lose their coping and language skills (Terr, 1994). It is the job of the therapist to recognize anxiety within the child and assist the child to reduce that anxiety in order to better assist them through the therapeutic process. Specifically, a traumatized child may become anxious when suspecting that a therapist is trying to confront his or her trauma for discussion.

Within this age group, it is important for a therapist to address with caution concerns of trauma. According to Gaensbauer (1994, 1995, 2002), preverbal children are able to maintain an internal representation of the trauma they experience for a considerable period of time. Therefore, while a traumatized child may be unable to verbalize the trauma, he or she retains the memory. According to Ogawa (2004), “trauma symptoms present as nightmares, play reenactment, and separation anxiety” (p. 20) and often the child is unaware that he or she is repeating the traumatic behavior or something related to the event (Terr, 1991). Consequently, while it is important for a therapist to be cautious when working with traumatized children in this age group, puppet play is an appropriate therapeutic avenue to address concerns regarding past traumas.

**Ages 6 to 8 years.** The next age group, 6 to 8 year olds, represents children at a more advanced stage of cognitive development. In this age group, children are completing Piaget’s
preoperational thought stage and entering the concrete operations phase from ages 7 to 11. In
this phase, “children develop the capacity to think systemically, but only when they can refer to
concrete object and activities” (Crain, 2008, p. 115). Put simplistically, a child is able to
understand relations around the ages 5 to 11 years old and is able to understand a situation from
multiple angles around the age of 7 (Hanney & Kozlowska, 2002). It is also around the age of 7
that “children begin to evaluate themselves based on their own perspectives instead of relying so
heavily on external evaluation. Their self-perceptions become more accurate, and their
grandiose self-perceptions become weaker. Therefore, children at this age become more
susceptible to internalizing negative experiences, which leads to the development of the child.
Another characteristic of children at this developmental age is the “acquisition of retrospective
viewpoints” (Ogawa, 2004, p. 22). This newly acquired ability to think systemically, concretely,
beyond the here-and-now, and from different perspectives is new to this age group’s cognitive
abilities.

Interestingly, puppet play can still be an effective tool within this age group. According
to Crenshaw (2005), traumatized children aged 7 to 9 years old may still be drawn to “symbolic
play due to developmental deficits or arrests” (p. 242). While a child at this age may prefer
board games and rule-bound contests (Crenshaw, 2005), puppet play may be a suitable
alternative for addressing issues within this age group due to the safety and distance that puppet
play has to offer from the intensity of traumatic situations. Puppet play can be introduced to the
client, and if the client seems interested and willing, it can be an effective tool with 6 to 8 year
old children.

Ages 9 to 11 years. Children age 9 to 11 years of age are completing cognitive
developmental phase of concrete operations according to Piaget’s theory. The child advances to
the final stage of Piaget’s phases called formal operations. In this stage, beginning at age 11 and progressing into adulthood, “young people develop the capacity to think systemically on a purely abstract and hypothetic plane” (Crain, 2005, p. 115) and develop “efficient well-organized actions for dealing with the immediate environment (Crain, 2005, p. 121). The use of puppet play within this population and during this stage of development needs to be addressed.

Puppet play may not be as effective with this age group as with previous ones. Children at this age continue to prefer board or rule-bound games (Crenshaw, 2005) and may find other forms of play immature, including play with puppets. According to Crenshaw (2005), “adolescents may be reluctant to focus on the painful feelings that constitute grief work, most are able to and willing to do so when they can call on various forms of creative expression in addition to direct verbalization” (p. 115). Therefore, while some children at this age group may be unwilling to participate in certain forms of creative expression, others may prefer to address issues through a non-direct form such as puppet play, drawing, or reenactments. It is the therapist’s responsibility to understand a client, offer avenues of expression, and accept what a client is comfortable doing through the therapeutic process.

**Conclusion**

As the research indicates, play is a natural, non-threatening, and straightforward way for children to express emotions, concerns, and innermost thoughts of which they may not even be conscious or able to verbalize. Since research indicates that traumatic events are common in childhood (Felitti et al., 1998), it is important for mental health practitioners to have an appropriate and effective therapeutic technique to address the themes and concerns that are prevalent within the population of 3 to 11 year old children. Some children may require a mental health practitioner’s assistance and guidance coping with and overcoming the psychological
consequences of a traumatic event. Play therapy is a viable avenue to address the themes and psychological and behavioral repercussions a child may experience as a result of a traumatic life event.

This paper discussed the play therapy of puppet play when working with physically, emotionally, and sexually traumatized children. It addressed the research and themes involved in each type of trauma. A brief play therapy history was also addressed, including the researched benefits of play therapy. Adlerian play therapy was also expanded upon, including its history and Alderian play therapy concepts. The specific therapeutic technique of puppet play therapy was discussed, including its history and how a mental health practitioner can carry it out in the therapeutic setting. Finally, the age groups of 3 to 11 year old children were reviewed with respect to the effectiveness of puppet play therapy within varying age groups based on development. As this paper supported, play therapy through puppet play is effective when working with traumatized children age 3 to 11 years of age. And as Erikson (1964) asserted: “to ‘play it out’ is the most natural self-healing measure childhood affords” (p. 222).
References


