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Child-Centered Play Therapy With a Seven-Year-Old Boy Diagnosed With Intermittent Explosive Disorder

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Child-centered play therapy (CCPT) has been supported as an effective method for working with children. A case study is presented that describes treatment using CCPT with a 7-year-old boy diagnosed with intermittent explosive disorder (IED). This case study delineates 16 sessions of play therapy with a registered play therapist. The behavioral problems the child exhibited at the onset of therapy were greatly improved at the conclusion of the sessions. The outcome of this case study supported the use of play therapy for children with IED.

Keywords: play therapy, intermittent explosive disorder, child-centered play therapy

Play therapy has been recognized as an effective method for working with children who are dealing with a range of issues, such as attachment disorders (Ryan, 2004), posttraumatic stress disorders (Ogawa, 2004; Ryan & Needham, 2001), autism (Josefi & Ryan, 2004), homelessness (Baggerly, 2003), trauma (Ogawa, 2004), and grief (Thornburg, 2002). Bratton, Ray, Rhine, and Jones (2005) asserted that play therapy is an effective intervention for childhood problems and is uniquely responsive to children's behavior, social adjustment, and personality. A meta-analysis of 93 play therapy research studies showed that play therapy is a viable intervention (Bratton et al., 2005).

Parental involvement and duration of therapy appear to enhance the effectiveness of play therapy (Bratton et al., 2005; Kottman, 2003; Landreth, 2002). Although play therapy can be effective without parental involvement, the addition of parents in play therapy increases the degree of success (Ray, Bratton, Rhine, & Jones, 2001), and researchers (Cates, Paone, Packman, & Margolis, 2006) have suggested that parent consultation is vital for positive outcomes in play therapy.

Because of children's unique developmental needs, such as developing self-awareness, self-monitoring, and self-resilience, play therapy serves as an important intervention for children with emotional and behavioral issues (Ray et al., 2001). The therapist in the case study of this article identified play therapy as an appropriate means of treatment for intermittent explosive disorder (IED), which can often be controlled through therapy and medication. The therapist, along with an

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agency psychiatrist, elected to isolate the use of child-centered play therapy (CCPT) without the interference of medication. This method of treatment was decided upon specifically because children lack the ability to think and reason abstractly and thereby will experience difficulty in communicating through spoken language (Landreth, Baggerly, & Tyndall-Lind, 1999). Play allows children to express their feelings in a comfortable way, by bridging concrete experience with abstract thought (Kot, Landreth, & Giordano, 1998).

IED

According to the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2004), IED is an impulse-control disorder where the evident component is the failure to resist impulse, drive, or temptation or to perform an act that is harmful to oneself, others, or material things. Consequently, IED may be described as aggressive episodes, referred to as *spells* or *attacks,* in which an explosive behavior is preceded by a sense of tension or heightened stimulation and is directly followed by a sense of release and relaxation. After an episode occurs, the individual may feel upset, remorseful, regretful, or even embarrassed about the behavior exhibited during the *spell*. Coccaro (2000) suggested that IED behavior is familial and linked to molecular genetics. The American Psychiatric Association (2004) suggested that a child with IED may have a history of repetitious severe temper tantrums, impaired attention, hyperactivity, and other behavioral difficulties, such as stealing and fire setting. In addition, the child's history might reveal deficits in socioemotional processing. For example, a child may perceive neutral faces as threatening. This suggests dysfunctional responses in the amygdale-prefrontal circuit (Coccaro, McCloskey, Fitzgerald, & Phan, 2007).

The disorder holds significant associations with comorbid mental disorders, particularly mood disorders, anxiety disorders, and other impulse-control disorders. While the diagnosis of IED should not be made when another Axis I disorder is better accounted for, current data suggest that IED and borderline/antisocial personality disorder do not invariably occur together (Coccaro, Posternak, & Zimmerman, 2005). According to Coccaro et al. (2007), IED confers functional impairment equal to or greater than most other Axis I and Axis II disorders. The high degree of explicit aggression is out of proportion to precipitating stressors, and other mental disorders or physiological effects of a substance or medical condition does not account for the extensive explosive behavior (Koelsch, Sammler, Jentschke, & Siebel, 2008). Recent epidemiological studies further suggested that IED is highly prevalent in the United States population (Coccaro et al., 2005). IED begins as early as childhood, peaks in the teen years, and diminishes in new cases after the age of 30 (Coccaro et al., 2005). Males typically meet the criteria for IED approximately six years earlier than females, which is consistent with other data regarding higher rates of male aggression. In addition, IED is more prevalent for males than females (Coccaro, 2000). Because of the early onset of the disorder and the explicit symptoms, early detection and immediate treatment may alter the course of the disorder and promote positive outcomes by adulthood (Coccaro, 2000). Unfortunately, treatment options are minimal, and patients often think of IED as an "ego-syntonic" disorder (Coccaro et al., 2005).

The treatments for IED currently include pharmacologic intervention and behavior therapy. Clozapine, an atypical antipsychotic, has been used to treat symptoms of mood lability, explosive hostility, self-mutilation, delusions, or hallucinations in patients with IED (Kant, Chalansani, Chengappa, & Dieringer, 2004). Clozapine, in modest doses, has shown clinical benefits, although there are serious side effects associated with this drug. The use of the anticonvulsant, phenylhydantoin, has led to a reduction of impulsive aggressive behavior associated with IED (Coccaro, 2000). The use of atypical antipsychotics in youth has a negative metabolic effect on weight; in addition, these drugs affect lipids and glucose levels in adults, but less is known about the impact on youth (Silva et al., 2008). Behavior management therapy could be used in conjunction with or in isolation of pharmaceutical treatment. Olvera (2002) agreed that behavior management therapy would be helpful, but also felt that the use of social skills training, cognitive behavior therapy, group therapy, and family therapy would also prove useful when working with this type of aggressive behavior. Olvera additionally believed that the therapy sessions should begin with a focus on social problem solving, such as identifying and articulating problems and moving into a training type focus that emphasizes impulsive reactions, how to consider consequences; and, ultimately generate alternative behaviors. This article will focus on the treatment of IED using CCPT without the utilization of medication.

CCPT

The approach used for this case study was CCPT, which was originally developed by Virginia Axline (1947) and further modified by Garry Landreth (2002). This approach allows for nondirective therapeutic sessions between child and therapist. The therapist follows Axline's eight basic principles of developing a caring relationship: being nonjudgmental, providing a safe environment, being sensitive to feelings, allowing the child to solve personal problems, trusting the child's inner direction, appreciating the gradual nature of the process, and establishing only necessary therapeutic limits that help improve the relationship. The child leads the session and the therapist follows his or her lead through reflection of content, feeling, and behavior. The relationship between the therapist and the child is the main focus in therapeutic play (Landreth et al., 1999).

Although there is no existing research that explores the use of CCPT with children diagnosed with IED, CCPT has been effective with children exhibiting symptoms of attention-deficit/hyperactivity disorder (Ray, Schottelkorb, & Tsai, 2007) and behavioral and emotional difficulties (Kot et al., 1998; Muro, Ray, Schottelkorb, Smith, & Blanco, 2006). During CCPT, children learn to discover their inner strengths and become more self-accepting, self-reliant, and self-directing. Children also develop an awareness of themselves and begin to assume responsibility and become resourceful in problem solving. The main goal is that these new competencies generalize from the playroom to the outside world (Landreth, 2002).

ABOUT BOBBY

Bobby is a 7-year-old boy who lives with his mother, older biological sister, two older stepsiblings, a foster sibling, and a stepfather. His stepfather is the only father Bobby has known, and he has been with Bobby since birth. Although Bobby has never known his biological father, he is aware of him through family stories. Bobby's mother describes his biological father as an alcoholic, drug addict, and sociopath, as well as diagnosed with bipolar disorder. When Bobby's mother was pregnant with him, his biological father attacked, robbed, and attempted to murder Bobby's mother. Bobby's father was incarcerated for this act and is currently serving a prison sentence; however, Bobby remains unaware of this incident. Bobby's mother worries her son will inherently become his father if she does not get him help.

Bobby came to therapy because his parents were concerned about his overly aggressive and explosive behavior. Bobby's parents believed that his strengths lie in his ability to be kind and gentle when he wanted to be, although they felt as though these times were slipping away with each passing week. They felt that it was Bobby's willful actions that determined his behavior. Bobby's parents indicated that he had always exhibited these types of behaviors, but they noticed it worsened as Bobby grew older. As a little boy, Bobby would upset easily, but he would also calm easily. He always threw temper tantrums and behaved in a manner in which they believed was developmentally appropriate for a child his age; however, once Bobby started first grade, his behaviors began to increase in intensity and frequency at both home and school.

At the onset of therapy, Bobby was getting into trouble at school four to five times per week. Bobby's mother defined trouble as the days in which either the principal, school counselor, or teacher would call mom to discuss Bobby's disruptive behaviors in class. Often times, this would result in Bobby's mother leaving work to pick up Bobby from school for the remainder of the day. A teacher reported that Bobby had "flipped out," punched holes in the walls, knocked down bookshelves, and was unable to keep his hands to himself on a frequent basis. Bobby was suspended on more than one occasion in first grade, during the early part of the school year. The school counselor, coupled with Bobby's teachers, was pushing toward immediate special education testing and removal of Bobby from this public school site to a "special" school dealing specifically with behaviorally aggressive children. These school personnel deemed that special education testing was necessary to specifically address any existing behavior issues (i.e., emotional handicap).

According to his parents, Bobby was very difficult to control. At home, he did not listen, was defiant, and was unafraid of anyone or anything. He did not respond to spankings, time outs, or removal of possessions. In addition, Bobby had kicked holes in walls, run from his parents in malls and other stores, dashed out into highway traffic, and kicked out a car window. When Bobby ran away from his parents in stores, it took both parents to restrain him during these temper tantrums. Bobby's parents also reported that he has impulsively flipped dressers, televisions, and destroyed an iPod. He broke many of his own toys and belongings. Bobby also exhibited baby talk at times when conversing with adults. His parents reported that

not all of the times were bad; they stated that "when he's good, he's really good, but when he's bad, he's really bad." They explained his good behavior as a child who listens, does what is asked of him, and does not act out. At the beginning of therapy, however, the bad times outnumbered the good. Bobby's parents brought him in for therapy because they did not know what else they could do.

After a thorough review of Bobby's history and a consultation between the agency psychiatrist, child psychologist, and licensed professional counselor (LPC) who was also a registered play therapist (RPT), he was diagnosed with IED. The team explored more common diagnoses for Bobby including oppositional defiant disorder (ODD), conduct disorder, and attention-deficit/hyperactivity disorder (ADHD), but determined that Bobby did not match the criteria for these diagnoses; however, he did for IED.

When Bobby's parents first decided to start Bobby with therapy, he began by seeing a psychoanalytic child psychologist within the agency. When he went to see this therapist, he did not respond well, refusing to interact or speak. There were minimal case notes that were passed from the psychologist to the RPT, as well as limited verbal conversation from one therapist to another. His parents felt it necessary that Bobby continue with treatment, thus Bobby was transferred to another therapist at the agency. The therapist was a LPC and a RPT with a doctoral degree in counseling including an emphasis in play therapy. The play therapist was trained in CCPT methods that determined the selection of the type of play therapy Bobby would receive. Bobby's progress was tracked through case notes. This article will discuss the changes in Bobby during his 16 CCPT sessions. This study was approved for publication through the authors' internal review board. Names have been altered for confidentiality.

PARENT CONSULTATION

Parental involvement increases the effectiveness of play therapy (Ray et al., 2001), thus parent consultation is recommended when working with children Cates et al. (2006) suggested that parent consultation is vital for a positive outcome in play therapy.

Bobby's age, his diagnosis, and the nature of play therapy demanded consistent communication between the therapist and his parents. When working with Bobby's parents, the therapist followed the suggestions of Cates et al. (2006). They suggested that therapists conduct an initial consultation where the parents, without the child present, are introduced to the playroom. Regular meetings between the therapist and parent are essential throughout therapy, and they suggested that providing the parents with an understanding of CCPT would be an additional important component of the relationship.

When introducing the new treatment to Bobby's parents, the therapist clarified that play therapy was not magic and would not change his behaviors overnight. In fact, the therapist stressed play therapy would progress similarly to an inverted bell curve. Bobby would display behaviors that represented a change early on in his therapy and then things might get worse for a while. Once Bobby regulated through therapy, his behaviors would be expected to again move in a positive direction and represent a more permanent change.

For the duration of treatment, the information exchange between parents and therapist was constant and key to Bobby's improvement throughout therapy. Prior to the beginning of each session, Bobby's parents met with the therapist in the playroom for about 15 minutes while Bobby remained in the waiting room. His behavior while waiting was appropriate for a seven-year-old boy. He played with toys while he waited in a quiet manner. At this time, the parents would update the therapist on Bobby's behaviors at home and school for the previous week. There were weeks in which the parents did not have much to report and other weeks in which they had multiple incidents and feelings that required conversation. During the first four session meetings, Bobby's parents reported that Bobby's behavior remained unchanged from the start of therapy. Bobby was misbehaving at home and at school. Bobby's teachers had always used a behavior sticker chart to measure Bobby's (as well as all students) behavior throughout the week and Bobby could earn a maximum of three stickers per day. At the start of therapy, he earned no stickers during any day of the week. During these first few weeks, he continued earning zero stickers per day while at school. His behavior at home was also not improving according to his parents. During these initial consultations, the therapist talked to Bobby's parents about their means for discipline and punishment and helped them to consider alternatives to spanking (i.e., choices).

At the consult prior to session five, Bobby's parents indicated that the special education test battery had begun. They felt scared by the prospect, as they truly believed the school was out to get Bobby only to remove him from his current setting. The parents revealed that the school counselor at Bobby's school was leading the charge in his removal, and they had very little trust for her. Bobby's parents indicated that, at this point, Bobby exhibited a decrease in the number of incidents at school over the prior two weeks. During week five Bobby had averaged one sticker per day on his school behavior chart. At home, Bobby's behavior was also taking a positive change, which his parents welcomed. These changes included an increase in listening and responding to situations in a productive way, and a decrease in damaging property.

By the consultation before session seven, Bobby's parents revealed that their son was again in trouble four to five times during the week while at school. The negative behaviors also continued at home. These behaviors, such as not listening, damaging property, and impulsively responding to situations were once again at the forefront for Bobby. His mother became frantic in her methods for punishing Bobby. She told the therapist about the methods she used (spanking, time outs, taking away items) but exclaimed that nothing worked with him. She had previously used these methods, however, she did not specifically select one method for its effectiveness, but rather behaved what she felt in the moment (e.g., feel like yelling–she yells; feel like spanking–she spanks). In presession and phone consultations, the therapist worked psycho-educationally with Bobby's mother over several weeks in the use of limit setting and the power of choices (Landreth, 2002) to integrate a consistent method of disciplining Bobby. Bobby's mother understood the benefit of these choices and said she would make an active effort to incorporate this method with Bobby. Bobby's mother also indicated that up until this point in therapy, the calls from the school regarding Bobby's behavior had been minimal until week eight. During week eight, Bobby's mother stated that the school counselor had been calling on a daily basis in hysteria about Bobby's classroom behav-

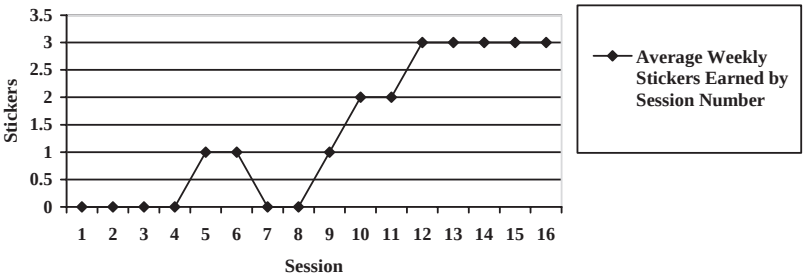

Figure 1. Stickers earned by Bobby in the week prior to labeled session number.

ior. As indicated by Bobby's parents in the past, they had little trust and felt very little comfort from the school counselor. Bobby's parents requested that the therapist speak to the school counselor in regards to Bobby's involvement in therapy and how the process play therapy works (i.e., not a magic solution).

Between the eighth and ninth sessions, the therapist obtained various release forms and made contact with the school counselor. The school counselor expressed her concerns about Bobby and his classroom behavior (i.e., acting out, disrupting other students) and the therapist-provided support. The counselor and therapist talked about using the ACT limit setting and choices method with Bobby, but the school counselor felt that the methods being used in the school and classroom were sufficient and did not feel that a change was necessary, only that Bobby needed to learn to comply with the school's current methods.

Starting with the ninth session and continuing through the sixteenth, Bobby's parents reported that he was once again doing well at home and were very pleased with his behavior. He returned to previously exhibited behaviors such as listening, responding to situations in a positive way, and displaying a near extinction of property damage. This was the longest period of time Bobby had gone without incident. They also reported that he was doing very well in school. His grades had increased, and his teachers reported a notable difference in his behavior. For example, Bobby now sat in his seat, kept his hands to himself, and raised his hand to speak. Bobby's parents kept the therapist abreast of the school behavior charts as therapy progressed in a positive manner (see Figure 1).

Prior to the fourteenth session, Bobby's parents and the therapist talked about termination, the process of termination, and the effects it may or may not have on Bobby. Just as with any termination in counseling, the therapist along with Bobby's parents agreed that Bobby would be notified that therapy would end in two sessions to prepare him for this change. Bobby's parents introduced the termination to Bobby, and, according to Bobby's parents, he took this information well and was able to process it in a functional manner. Bobby did not display any signs of distress that therapy would soon end. This response was disproportionate to the IED diagnosis but also welcome by the parents and the therapist. At the conclusion of therapy, Bobby's parents indicated that they were very pleased and understand a great deal more about the use of play therapy for children.

When Bobby's parents followed up with the therapist a few days after the final session, the success of CCPT was evident. They indicated that his behavior at home and school was "wonderful." They also reported that the special education testing,

deemed necessary by school personnel earlier to address behavioral issues (i.e., emotional handicap), was completed. From the battery of tests, the district school psychologist detected no behavioral issues; however, Bobby struggled in the area of language arts and would be classified for special services in that area. No other specifics were supplied to the therapist. Bobby's parents did not provide the therapist with an official report or breakdown of individual assessments that took place during the testing. An additional anecdotal follow-up that supported the use of CCPT with Bobby occurred a few months after termination when Bobby's mother happened to see the therapist in the community and indicated that his behavior was still on track. Behaviors that had existed at the start of therapy (i.e., temper tantrums, destroying property, running away) were "few and far between."

SESSIONS

Session One

The play therapy room was set up in accordance to the suggestions of Landreth (2002), with nurturing toys closest to the therapist and aggressive toys the furthest away from the therapist. During the first session, Bobby explored the playroom and actively used all types of toys (i.e., aggressive, creative, manipulative). He was particularly fond of the aggressive toys but actively played with all during this session. Bobby behaved in a manner that was typical of a first session, exploring and getting acquainted with the playroom. His play with the individual toys was consistent with the given toy. For example, he played with a car as though it was a car. The therapist used reflection of content and behavior throughout most of the session, incorporating reflection of feeling when appropriate. Bobby remained completely focused on playing, kept his back to the therapist, and did not acknowledge the therapist in any way.

Session Two

Bobby entered the playroom, immediately went to the aggressive toys, and continued to play with only the aggressive toys throughout the entire session. Again, he played with these toys in a manner consistent for the given toy. For example, he played with the handcuffs as though they were handcuffs. During this session, the therapist introduced limit setting for the first time, which continued throughout Bobby's time in therapy. Limits that were set included the destruction of toys, destruction of agency property, and danger to self. The therapist used the ACT limit setting method with Bobby: A–acknowledge the feeling, C–communicate the limit, and T–target two alternatives (Landreth, 2002). In this particular session, two limits were set; one referred to Bobby destroying a toy, and the other pertained to Bobby shooting the therapist with the dart gun. Bobby listened as the therapist used the ACT method to set the limit and give two alternative choices. During the first limit, Bobby chose one of the alternate choices. During the second limit, however, Bobby chose a third, albeit acceptable, choice. The therapist dis-

cussed Bobby's choices in both instances. Again, Bobby remained completely focused on playing, kept his back to the therapist, and did not acknowledge the therapist in any way.

Session Three

During this session, Bobby chose to focus on the creative expression toys and crafts in the room. The therapist facilitated creativity during this time of play. He spent a majority of his time playing with the play-doh and creating crafts for his mother out of construction paper, tape, and pipe cleaners. Bobby took his time with each of the projects that he produced and was very thorough in their completion. The therapist reflected on the importance of these projects and the feelings (e.g., happiness and joyfulness) they elicited for Bobby. During this session, Bobby turned to face the therapist as he played, however without making eye contact.

Session Four

Session four brought about some changes in Bobby in the playroom. Bobby was very talkative in all of his play during this session, and he used the toys to talk to each other. He briefly played with the aggressive toys (i.e., dart guns, handcuffs), and then moved to play with the manipulative toys (blocks and Legos) for the first time, then back to the creative expression crafts where he had left off the previous week, creating a cycle within his play during the session. He spent the majority of the session creating more crafts for his mother. This time his focus was more intense than the previous session. The therapist reflected this to Bobby while he worked. Bobby began to become extremely focused on the smallest of tasks, becoming easily frustrated when what he was trying to do did not work. When the therapist would reflect his frustration, Bobby would deny it and become agitated for a minute, then return his focus to the project he was working on.

Session Five

Bobby entered the playroom ready to create some more crafts for his mother as the therapist reflected this excitement. He became easily frustrated and put this activity aside to play with the aggressive toys. The therapist reflected Bobby's frustration, but Bobby moved on to play and did not respond. He continued to play with the aggressive toys for a majority of the session, shooting dart guns and playing with the handcuffs, only pausing for a few minutes to attempt his craft again. When the session was through, Bobby threw away his craft because he was frustrated that it did not look the way he intended.

Session Six

Bobby's continued frustration turned to anger as he played with the toys in the playroom during session six. The toys were all used in an aggressive manner with instances of yelling and screaming, hitting, and punching throughout Bobby's play session. Bobby spent particular time with the puppets and puppet theater, agility, creative expression, and dress up toys. During this session, the therapist needed to set two limits with Bobby. One limit was in reference to damaging the puppet theater, and the other referred to poking a hole in the bongo drum. Bobby responded to the limits by changing direction of his play before the therapist had completed the ACT.

Session Seven

Bobby's expressed aggression increased since the previous sessions, and he became destructive with all toys during his play. The therapist reflected Bobby's anger and frustration while he played with the toys in this manner. During this session, Bobby tossed sand on several occasions, crushed and destroyed a small car, and broke a dart for the foam dartboard. The therapist set four limits with Bobby during this session, all in reference to the above damage of toys and sand. In all instances, the toys were broken and the sand was tossed as the therapist set the limit. Bobby remained in the playroom and would redirect his play during the time of the limit setting, but would return to the area and play with the sand or toys in an appropriate manner a few minutes following the limit. The therapist reflected this behavior to Bobby.

Session Eight

When Bobby came into the playroom for session eight, he proceeded to the dress up area. Bobby dressed up in a black mask, army helmet, and shield of armor (including arm and leg armor). Bobby then attached aggressive toys in the playroom to his person using the handcuffs, rope, and other dress up accessories. He then proceeded to sit down, hold out the machine gun, and shoot it for the remainder of the session. The therapist reflected Bobby's behavior and feelings of anger and frustration throughout this session. Bobby's affect was quite distant during this session, however, and when the therapist reflected, Bobby did not seem to pay attention. No limits were set.

Session Nine

At the start of session nine, for the first time, Bobby did not want to go into the playroom. The therapist sat with Bobby in the waiting room with his parents and reflected on his not wanting to go into the playroom. After about three minutes, Bobby decided to enter the playroom. Once in the playroom, Bobby became very

violent for the first time and aggressive with all of the toys. Bobby broke two toys and threw others across the room. Four limits were set during this session; two pertaining to the breaking of toys and the other two to the destruction of property (i.e., toys thrown were made of wood and hit the walls). When the therapist reflected Bobby's anger, Bobby responded for the first time that the toys were angry and not him.

Session 10

Similar to session nine, Session 10 began with Bobby not wanting to enter the playroom. The therapist again sat with Bobby and his parents in the waiting room reflecting Bobby's feeling about not wanting to enter the playroom. Five minutes later, Bobby made the decision to go into the playroom. During this session, Bobby tossed the playroom. Every toy was removed from the shelves and areas designated during play. The therapist reflected Bobby's decision to move from one toy to another throughout the session. Although no limits were set, the session ended five minutes early due to the extra clean up time between sessions because of the room being tossed.

Session 11

The eleventh session presented a turning point with Bobby. The session began when once again Bobby did not want to go into the playroom. The therapist worked with Bobby as he hid in his stepfather's shirt in the waiting room. Reflections on feeling and content led Bobby into feeling comfortable enough to enter the playroom. Bobby became more frequently agitated as the five minutes in the waiting room continued. He yelled and hissed at the therapist prior to running down the stairs and halls of the agency. This was the first time in which Bobby directed his affect toward the therapist. The therapist slowly followed Bobby continuing to reflect on what was happening and enlarging the meaning of what Bobby was saying and doing. Bobby and the therapist found themselves on the second set of steps, where Bobby screamed at the top of his lungs "leave me alone," while hitting and punching the wall. Bobby growled and screeched at the therapist. His behavior escalated into violence. Bobby began to pull and yank at the stairway railing trying to pull it from the wall. The therapist calmly set limits surrounding the destruction of property and Bobby responded by stopping for the time being. The limit setting increased in frequency and Bobby's irritation grew as time passed. The therapist and Bobby remained on the stairs for the duration of the session. As the therapist ended the session for the day, Bobby instantly turned off the behavior, ran up to his stepfather, thanked the therapist, and walked off. The therapist was concerned about the confidentiality issues of working with Bobby on the stairs; however, it happened to be a very quiet night at the agency so there was only one interruption, at which time both Bobby and the therapist remained quiet as the person passed through the stairs. Bobby's stepfather was very patient with the process and remained in the waiting room for the entire session. Although not

evident by his behavior during the session, the positive effects occurred in the next few weeks as Bobby continually hit the three-sticker mark per day— every day.

Session 12

In this session, Bobby willingly returned to the playroom. Once in the playroom Bobby only played in the kitchen area and enjoyed the nurturing toys throughout the entire session. This was the first time that he had done so. These were toys that Bobby did not pay much attention to prior to this point. Bobby played with the baby dolls for the longest amount of time while the therapist reflected on his behaviors regarding his feelings of caring and gentleness. There were no limits set during this session.

Session 13

When it was time for Session 13 to start, Bobby was a little reluctant to enter the playroom, but after about 15 seconds, Bobby entered. Once in the playroom, Bobby played with the toys in a manner consistent for the toys. For example, he played with the airplane as it was an airplane. There were no limits set during this session.

Session 14 and 15

During these two sessions, Bobby entered the playroom without hesitation. Once in the playroom, Bobby played with the Legos for the entire session. The therapist reflected Bobby's play throughout and no limits were set during these sessions.

Session 16

At this final session, Bobby spent time with all types of toys in the playroom. He took the time to touch each toy. The therapist reflected this process to Bobby, but there was no response. At the conclusion of the session, Bobby gave the therapist a big smile and a thank you.

Overview

Although Bobby did not talk to the therapist often during therapy, he intermittently communicated by correcting the therapist's reflections. Bobby communicated most often through the types of toys he selected and how he played with the toys he chose. Through this play, Bobby was able to express his thoughts and feelings in his own way in an environment that was safe for him.

This particular case of a seven-year-old child diagnosed with IED demonstrates the positive impact that early intervention of CCPT may have on reducing emotional/ behavioral issues. The decision of the parents to choose therapy over medication indicates the need for additional clinical resources, such as play therapists, for parents who seek medication-free treatment options. As seen in this case study, Bobby improved behaviorally and emotionally through 16 sessions of CCPT. Ongoing consultation between parent, therapist, and child created a strong therapeutic relationship that helped Bobby learn to control behaviors exhibited from IED.

CONCLUSIONS AND IMPLICATIONS

This case study is an overview of the use of CCPT with a seven-year-old boy diagnosed with IED. It documents a session-by-session detail of Bobby's progress through play therapy and considers the aspect of parental involvement with CCPT. This type of play therapy, CCPT, allows for therapists to exhibit unconditional positive regard for children, allowing them to feel safe and secure. In Bobby's case, Bobby was able to feel secure enough to express the struggles of his outside world. Although this was not directly reflected to Bobby, it was an innate part of the process (Landreth, 2002). Through his play and reflection from the therapist, Bobby worked through his issues. This became evident in both his behavior at home and in school by the end of therapy.

In this case, the cooperation of Bobby's mother was crucial. After learning and applying ACT limit setting and using the power of choices with Bobby, she took therapy beyond the playroom. A combination of home, school, and therapeutic environments helped to fully develop this process. Although the teacher did not participate in the ACT method, she did participate in charting and recognizing improvements in Bobby's behavior while at school. The circle of support allowed a continuum of uninterrupted learning for the child.

IED, an impulse control disorder, improved through play therapy sessions in the case of Bobby. This is the first documented case of the use of CCPT with IED. Determining success that transfers into helping other children with IED or similar disorders can only be concluded by furthering and continuing research in this area. This case made it evident to the therapist that Bobby experienced the positive effects of CCPT. Although Bobby started his therapeutic journey out in a psychoanalytic psychologist's office, he ended it in the play therapist's office and this is what the authors believe helped Bobby. Adults use language to communicate with one another, while children use toys as the primary medium of expression (Trotter, Eshelman, & Landreth, 2003). Children are not miniature adults. They require an alternate form of emotional healing, which is found in play therapy (Landreth, 2002).

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