

Feature Article:

Managing Profanity in Play Therapy

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Question: Should children's verbalizations, like profanity, ever be limited? Are there any rules about limiting profanity in the playroom?

Planning ahead

There are some useful guidelines, not rules, about what behaviors are limited in the playroom. Planning is one of the major keys to successful limit setting. For instance, before beginning PT in a new setting, the play therapist should look at it through a child's eyes. Scan the room for any geographical features, furnishings, special contents, etc. that may require a limit to be set. If time is taken to mentally compose, then write down the wording of each potential limit; limits will be smoothly incorporated into the session. In relations to limiting verbalizations, particularly profanity, it is useful to think ahead about each client and how her/his situation will influence limit setting decisions. There may be clients, for whom setting a limit on profanity would increase their attempts to use it; while other clients might feel safer as a result of the limit. Timing of the limit would also influence the decision. If profanity were used in the first or second PT session, the play therapists' response might be different than if it were used in a later session. Planning ahead also involves looking inward. Graduate students and play

therapists at the beginning of their careers will find it useful to carefully and objectively, examine their attitudes about and perceptions of individuals who use profanity. If the play therapist suspects that s/he suffers from excessive prudishness or embarrassment when confronted with profanity or that s/he is rigid in her/his attitude against it; s/he may want to work to overcome this. Often a colleague can be asked to respond candidly to questions regarding possible attitudes.

Assessment Value of Unconditional Positive Regard in the Presence of Profanity

Consider this modified version of an actual situation involving six year old Marcus, whose foster mother was distressed about his use of profanity and vulgar gestures. Because of its value in establishing a therapeutic relationship, and because it yields such valuable assessment data; even if I plan to use a more directive approach later, I always begin play therapy with at least two or three pure client-centered (CC) PT sessions. Right after a limit was set in his first PT session, Marcus placed his mouth against the skin on his inner arm and blew on it, telling me he'd just performed a bodily function involving expelling air. I reflected his words in a tone similar to his. He immediately corrected me with, "I didn't really; it was just my arm." Then he switched to a new play theme. (Play disruptions tend to reflect a child's discomfort or an inaccurate play therapist verbalization. In this situation,

the reflection was verbatim what Marcus said; so discomfort is indicated.) In the second session, Marcus violated one of his case manager's rules against hugging without asking for permission. He glanced at the mirror while he was hugging me and "flipped" the middle finger of his right hand to an upright position and gestured with it toward the mirror. I briefly reflected the gesture (positional empathy) while saying, "you held your finger up that way." He denied it by saying, "that was my ring finger; no, it was my pinkie." Similar situations happened throughout the first three CC PT sessions.

Were there any benefits of quietly reflecting the words/gestures? By reflecting what occurred as it occurred, I was able to see this "problem" behavior occurring in a naturalistic way. Each instance of profanity or vulgar gestures closely followed a behavior or event that he might have perceived as embarrassing to himself. It was probable that Marcus was using profanity to "cover up" or relieve anxiety about having done something "wrong" or embarrassing. Once I realized this, I could reflect this reality to Marcus and, hopefully, "uncover" it and bring it into his awareness. I said, I've noticed that when you make a mistake, you get angry." Marcus ignored me, turned his face and body away from me, and changed play themes. The second time I said it, Marcus screwed his features into a frown, balled up his fists, and said, "and I get really mad too!"

He had acknowledged this observation of his reality, suggesting that I would be able to move closer with my reflections' such as saying "you made a mistake, so you made a joke about fa __ ing to cover up your feelings." If he was able to accept this reflection without resistance; I could move to: reflecting more adaptive behaviors as they occurred in CC PT, or designing a cognitive-behavioral (CB) PT intervention to teach Marcus more socially adaptive ways of coping with his anxiety and embarrassment. If I had placed a limit on the profanity and vulgar gestures, when they occurred in the early sessions, I may not have assessed this factor that favorably influenced PT outcomes.

What are the Consequences When Words Are Limited?

A simpler guideline about whether or not to place limits on profanity comes from the fact that, without consequences, limits cannot be enforced. In addition to ending the play session, I use removal of offending play material as a consequence (e.g. (1) If the truck is thrown, it will be put in the closet. (2) If the sand goes out of the sandbox, the lid will be put on the sandbox.) The removal of play material provides a logical connection between the behavior being limited and the consequence, a connection that most children understand easily. It also allows the play therapist to use ending the play session as a consequence for more serious

behaviors, usually involving child and/or therapist safety, e.g. physical aggression against the therapist, sexual acting out. O'Connor (1991) says ending the play session as a consequence is counter-productive because it removes the child from the positive effects of play therapy. It is difficult to enforce limits on verbalizations without ending the play session.

Using Therapeutic Outcomes as a Basis for Limit Setting Decisions

Often, instead of looking at what behaviors should be limited, it is more useful to look at reasons for setting limits. Sometimes a play therapist may make a decision regarding a limit because of her/his own (unexplored) assumptions, fears, biases, etc. Or simply out of habit. (An example of an unexplored assumption would be a play therapist who limits profanity because of an assumption that profanity is "wrong, bad, or immoral.") I believe that a more useful guidelines for play therapists to follow in making decisions about what to do during therapy is: When a play therapist makes a decision to do (or not do) something during a play therapy (PT) session' s/he should be able to respond positively to the question, "what therapeutic outcome will occur as a result of my decision?" In other words, decisions about what to do (or not do) in a PT session should be decided on the basis of whether or not a decision will result in a positive therapeutic outcome. In theory-

based practice, whether or not outcomes are/will be therapeutic is grounded in the theory. The theoretical frameworks/s, guiding the play therapist's practice, have the answers regarding what practice decisions will have therapeutic outcomes.

Let's look at how developmental and client-centered (CC) theoretical perspectives would guide a decision regarding whether or not the child's verbalizations should have limits placed on them.

Landreth (1991) listed six CC PT objectives for the play therapist. When the play therapist uses the CC PT theoretical framework as a guide to decision-making, instead of "should children's verbalizations, like profanity, ever be limited? The question becomes, "how can limit-setting be used to assure that CC PT objectives, for the play therapist, are met?" Landreth's objectives say the play therapist should":

1. establish an atmosphere of safety for the child;
2. understand and accept the child's world (and) by relinquishing adult reality, see things from the child's perspective;
3. encourage expression (by the child) of (her/his) emotional world'
4. establish a feeling of permissiveness allowing/encouraging choices'
5. facilitate decision making...opportunities (for the child) that promote self-responsibility; and

6. provide the child with an opportunity to assume responsibility to develop a feeling of control (pp. 154-155).

Case example: Landreth's (1991) six CC PT objectives for the play therapist should be considered as a whole, rather than looking at each objective in isolation. Another example is used to clarify this. Alicia is a seven-year-old, who was abused by the adults in her nuclear and extended family. Any attempts, by her, to avoid this abuse or respond verbally to it were severely punished. Once she said "damn" in front of her father and was beaten and locked in the cellar without food. The case manager says that Alicia is particularly fearful of retaliation to profanity. One of the behavioral results of the abuse seems to be an assumption by Alicia that she is "bad." She expends a great deal of time and energy demonstrating just how "bad, rotten, and reprehensible" a person she is. She tests limits. She makes messes and tells the play therapist to clean them up. She tries to insult the play therapist. The play therapist follows the guidelines for empathic listening, and reflects the content of Alicia's behaviors and verbalizations with the accompanying cognitions and feelings. When Alicia angrily tells her, "I don't have to listen to an ugly person like you – you have ugly hair and big feet" the play therapist reflects, "you're angry at me, so you're telling me I have ugly hair and big feet." One day, Alicia looks at the play therapist and says, "I know you'll get mad and beat

me. I know how to make you do it." The play therapist reflects, "You're telling me you think I'll hurt you like other people did, and you know how to make me. Then Alicia screams at the play therapist, "You're a stupid, damn, shrink!" After she says it, Alicia waits fearfully for a response.

Landreth's (1991) first objective says that the play therapist should establish an atmosphere of safety for the child. It is useful to ask, how would limit-setting establish an atmosphere of safety for this fearful child? This requires the play therapist to ask: What do I mean by safety? What child and/or therapist behaviors/verbalizations would be "unsafe?" In therapy, safety allows for optimal psychological growth and development, while allowing for the possibility that mistakes will be made. Safety means that the child is protected from harm. With this in mind, the play therapist knows that any child and/or therapist behaviors/verbalizations that could result in (physical and/or psychological) injury threaten the child's sense of safety.

In addition to whether or not Alicia's words pose a threat to her safety; the play therapist's decision about whether or not to place a limit on her words requires understanding of Alicia's emotional world. Alicia's reality has resulted from her illogical (magical thinking) assumption that, because adults in her previous experience all thought she was bad and hurt her, all adults will

think she is bad and hurt her. One of the things that "made" her bad was saying "bad" words; so she thinks if she says a bad word, an adult will think she's bad and hurt her. To reflect Alicia's "damn" back to her without comment or limitation will not result in any clear therapeutic gains and it could result in some emotional harm. Reflecting her "damn" back to her also reflects a less important aspect of Alicia's reality to her. It is not as important to reflect the word as it is to reflect the assumption (about the child's world) that it represents. So the play therapist begins her response by reflecting that assumption, "you think saying 'damn' will make me hurt you." (Note that in this reflection the phrase is passive, "saying damn..." as opposed to the active, "you said damn..." or "you think I'm a damn..." The emphasis is not on who is saying the word.) Then the play therapist uses a limit setting statement, "the rule is I can't be called 'damn.'" S/he may, if she wishes, follow that limit with a statement that implies an alternative as recommended by Landreth (1991): "this (indicating a stuffed animal or other object to represent a person) can be called 'damn.'" (Again, the passive wording places emphasis on the behavior rather than the person: "I an't be called..." as opposed to the active, "you can't call me..."). If possible the play therapist should continue to make the point: "you thought I would act like other grown-ups and hurt you. The rule is, you can't be hurt by saying words." (This

rather symbolic limit gets an important message across about the child's playroom world.) Again, she can offer an alternative with a passively worded statement such as, "damn can be said to this (indicating stuffed animal or other object)."

According to limit setting procedure, the play therapist should be ready with a consequence. This is an instance where it would be appropriate to use ending the session as a consequence. Stating, "if I get called 'damn' again, the special play time will be over," gives the message that the play time is ended if the child gets hurt. This emphasizes the safety of the playroom. If the child doesn't continue to the point of having the consequence enforced; the play therapist can be alert to opportunities to make reflections such as, "you knew it was safe to call the bear 'damn'. You know you can't be hurt in here." Such reflections emphasize safety. During

advance planning, the play therapist decides how to emphasize the therapeutic nature of the consequence if it needs to be enforced. A directive play therapy intervention can be carried out in another location (of the building or office). Examples for the focus of the directive play therapy intervention include: (a) feelings work, especially fear and anger; (b) the fact that Alicia did nothing wrong; and (c) why it's wrong for grown-ups to hurt children. I used a modeling story about a baby lion, who learned that the grown-up female lions would make sure that the play place would be a safe place. Here again, by using CC PT theory to direct responses in the playroom, the play therapist assures that interventions are more likely to have a positive therapeutic outcome.

Answers to "PT Questions" are my views and may differ from those of other play therapists.

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