Learning About the Importance of Play for Grieving, Dying, and Hospitalized Children

By Erik van de Ven

My first exposure to the therapeutic value of play with children was as a volunteer working for a home hospice in 1996. I was supporting two brothers, ages four and seven, whose father was dying of cancer. On the first of what would become twice weekly visits over the next several months, I was expecting to spend most of my time with the children involved in serious conversations about their father and his illness. Instead my visits were filled with play of all kinds. This experience proved to be the starting point for my interest in the therapeutic benefits of play. It was also the start of my ongoing experience working with grieving, dying, or hospitalized children, and it is one of several factors that led to my interest in the field of play therapy.

My educational and professional background is in information technology and management not in mental health, social work, or education. My experience with play as therapy comes from close to 20 years as a volunteer working with children who have experienced illness, grief, and loss and primarily in a home, hospital, or hospice environment. In these settings the benefit of play therapy comes from returning some normalcy and some control to a situation that for the child is far from normal and often completely out of control.

Working with Hospitalized Children

The experience of being hospitalized, with its inherent stress and anxiety, seems to create a situation where the child has an even greater need to communicate through play, to make sense of the experiences and adapt to them (Webb, 1995). According to Golden (as cited in Landreth, 2012, p. 41) the value of play therapist's toys is as important as the surgeon's tools for the overall health of the child. Child Life Specialists often use play therapy methods as a means to relieve stress and acclimatize children to medical instruments and procedure. These are generally quite directive approaches but evidence suggests that the use of non-directive play therapy, for example allowing children the freedom to act out procedures they have undergone, is also beneficial (Landreth, 2012). In my own experience of working with hospitalized children, there is also great value in the relationship itself; in letting the child lead and following along, in treating the child as a person and not as an illness, in simply being with the child and being fully engaged with them in the activity of their choice. This visibly relieves anxiety and gives back some control to the child.

Working with Dying Children

Children who are dying are progressively losing control over their lives, and often their bodies, as their illness progresses. In addition to dealing with the anxiety related to their illness there may be additional stress caused by the child seeing the effect of their illness on parents and siblings. Establishing a relationship with a dying child and allowing the child to direct the relationship gives back some control, and allows the child to temporarily feel the normal pleasure and fun associated with play. Being allowed into a relationship with a dying child is a privilege and the time spent together is often like an oasis for the child (Landreth, 2012). In working with dying children I've found that the play and narratives that occurred in the time we spent together weren't shared with anyone else. This again highlights the importance of the relationship.

Working with Grieving Children

"To grieve, then play, then grieve. This is the way of children." (Johnson, 1999, p. 86) Children grieve in "waves" and will often switch to play as a means of regulating emotions when they become overwhelmed. In this manner children can go back and forth between grieving and playing, or even grieve and play at the same time. For children who have experienced the death of someone close to them, play allows them to work through, integrate and make sense of the separation and loss that death brings (Hersh, 1995). In addition, children are often sheltered from the adults' grief and may be told certain things about the death to soften the blow (Sanders, 1995). This can cause confusion and anxiety for the child. The child may also feel isolated as friends and others in their lives may not know what to say about the death. In the case of my experience working with the two brothers whose father was dying of cancer it seemed that their mother was more distant as she was dealing with her own feelings, and her focus was on caring for the father. Meanwhile, their father was slowly withdrawing, no longer able to spend time with them. In addition, daily routines were upset as visitors and health care workers regularly came in and out, and their father's illness became the focus of the home. Both before and after the father's death I was the only one whose visit was focused solely on them. I was the one constant, the one who was there for them and for them only. They were the centre of attention and through play we created a special relationship. They led and I followed. They created fantasy worlds, made up fantastic stories, played sports and games, and let their imagination run wild. However, often during those times the effect of their father's illness would be apparent in their choice of activity, in their actions, and in what and how they communicated with me and with each other.

Erik van de Ven

Establishing the Relationship

My natural way of playing with children is to let them lead the way. I am fascinated by the imagination, curiosity, energy, and intensity with which children engage in play. My tendency is to observe closely but to participate fully in the play, if invited, and I feel privileged to be allowed into the child's world at those times. "I want to be more accepting of the child in me. Therefore, I will with wonder and awe allow children to illuminate my world". (Landreth, 2012, p. 5) I consider the relationship with the child to be of paramount importance. It is essential for the child to know that I am willing to listen to anything they have to say, that no question or topic is too silly or too difficult to talk about. Every feeling and question is valid and I am ready to listen to it (Coloroso, 1999). In dealing with children who have experienced trauma I often ask straightforward questions, and I always answer the child's questions honestly, directly, to the best of my ability (saying "I don't know" is OK), and in language that is age appropriate. Although I prefer developing longer term relationships over time I believe that benefits can be achieved through a relationship established in even a single session. I tend to use humour to establish an initial connection with a child, and I've often found that saying or doing something completely unexpected can help to break the ice.

My Personal Theory of Therapy

In developing my personal theory of play therapy, and as someone new to the formal theoretical models, I consider the following to be important: a) play itself is therapy and the therapist should be a participant, a full partner in the play, and not only an observer; b) the relationship between the therapist and the child is essential; c) the therapist should respect the child's ability to make decisions; the child should lead and the therapist should follow; d) benefits can be achieved in a small number of sessions if the therapist is able to make a connection with the child; e) the special relationship is based on the fact that the time the therapist and the child spend together is focused only the child and not the problem; the therapist is there for them and for them only; f) the therapist should treat all questions as important and relevant, and should answer all questions honestly and directly; g) the play and the relationship should give the child a sense of accomplishment and mastery. My personal approach to working with grieving, dying or hospitalized children is therefore strongly non-directive and child-centered. However I do feel that in certain cases an initial non-directive approach can be used to determine what could be a very directive, goal oriented activity. My personal theory will no doubt undergo many revisions as I eventually gain experience in more formal clinical settings.

References

Coloroso, B. (1999). Parenting through crisis. Toronto, ON: Penguin.

Hersh, S. P. (1995). How can we help. In Doka, K. J. (ed.), Children mourning mourning children (pp. 89-95). Washington, DC: Hospice Foundation of America.

Johnson, J. (1999). Keys to helping children deal with death and grief. Hauppauge, NY: Barron's.

Landreth, G. L. (2012). Play therapy: the art of the relationship. New York, NY: Routledge.

Sanders. C. (1995). Grief of children and parents. In Doka, K. J. (ed.), Children mourning mourning children (pp. 69-83). Washington, DC: Hospice Foundation of America.

Webb, J. R. (1995). Play therapy with hospitalized children. International journal of play therapy, (4)1, 51-59.

About the Author

I am a manager in a financial institution by profession but my passion is working with children, specifically children who are dealing with trauma. I have had the great privilege of working with children who are dealing with illness and death in a volunteer capacity for many years. I am a new CACPT member and I recently completed the Level 1 Play Therapy training.

Erik lives in Toronto. You may connect with him at erik.vandeven@rogers.com.