Winnie the Pooh's Christopher Robin

Introducing the Character

Christopher Robin is the central figure in the fictional works of British author A. A. Milne, which include *When We Were Very Young* (1924), *Winnie the Pooh* (1926), *Now We Are Six* (1927), and *The House at Pooh Corner* (1928). The fanciful stories feature 6-year-old Christopher Robin and his stuffed toys Winnie the Pooh (a bear), Eeyore (a donkey), Tigger (a tiger), and mother and son Kanga and Roo, as well as the woodland creatures Owl and Rabbit. Since their publication, the books featuring Christopher Robin and his friends in the Hundred Acre Wood, most prominently Winnie the Pooh, have been made into a number of animated films. The most famous of these movies are *The Many Adventures of Winnie the Pooh* (Lounsbery & Reitherman, 1977) and *Winnie the Pooh and the Blustery Day* (Reitherman, 1968), both created by the Walt Disney Company.

Although never introduced to the reader or audience as imaginary characters, it is clear that all of Christopher Robin's friends are his beloved stuffed animals brought to life through his vivid imagination. Each one personifies a unique quality, including Winnie's loving innocence, Owl's wisdom, Rabbit's cynicism, Piglet's fearfulness, Tigger's love for life, Eeyore's sadness, and Kanga and Roo's compassion. Although the adventures of Christopher Robin and his friends clearly are flights of imagination, the lessons learned have provided generations of children and grown-ups with bits of wisdom that somehow, yet invariably, get lost along the way to adulthood. As we imagine him, Christopher Robin may be experiencing the impairments in human social interaction, and restricted interests and activities, that together are characteristic of Autism Spectrum Disorder. Details follow in the basic case summary and diagnostic impressions below.

Basic Case Summary

Identifying Information. Christopher Robin is a 6-year-old boy who has been at the Hundred Acre Day School for Boys for just over 3 months. He resides in London with his parents. Although Christopher has done

adequately in his studies thus far, he prefers creative and solitary activities, including drawing, play acting, and free play on the school's spacious athletic fields. He appears to be an active and appropriately energetic boy. However, he was remarkably withdrawn and reluctant to engage the counselor during his intake meeting. Although ample toys, games, and distractions were available to Christopher in the play therapy room during the interview, he exclusively held, talked to, and played with the stuffed bear (he named Winnie), stuffed pig (he named Piglet), and stuffed rabbit (he named Rabbit) that he brought with him to the session.

Presenting Problem. Christopher arrived for an evaluation session on referral from the school counselor and with his parents' permission. Initiating the referral were his teachers', classroom assistants', counselors', and parents' concerns about his lack of interest in engaging with his classmates and peers, his lack of initiative seeking out any objects or themes of play beyond his stuffed animal collection, and his failure to make eye contact or meaningfully pay attention to and respond to his teachers at school.

Likewise, his parents report that at home he plays exclusively with his stuffed animals, declines any solicitations by his father to try soccer or other sports or outdoor activities, rejects encouragement by his mother to play board games or video games, and does not socially interact at all with their weekly housecleaner or with adults or children who are neighbors.

The Day School's headmistress, Eloise Rathbone, has become concerned that Christopher may not be "ready for school" or may have needs beyond the school's resources. Like his teachers, she is concerned because he has had some difficulty adjusting to the social demands of leaving home every day to attend school; during the day he mainly spends his time with isolative behavior, spends excessive time in imaginary play with his stuffed animals, and shows a heightened level of distractibility during his classes. However, Ms. Rathbone does describe Christopher as an otherwise "very pleasant child."

Background, Family Information, and Relevant History. Christopher was born in the socioeconomically affluent London suburb of Blustershire, the only child of Alexander and Annaleise Robin. His parents, who are well-established and loyal patrons of the arts throughout London, report that they had hoped throughout 16 years of marriage to have a child and finally were successful with the birth of Christopher. Christopher's father

described himself as a prolific and somewhat driven and reclusive author of children's books who spends most of his days cloistered in his study and, by his description, has been only rarely available to the family. Christopher's mother, Annaleise, reports that she has been extensively involved in the Labour Party in England and is often out of the house during days, evenings, or weekends. A part-time nanny, Olive Rockwell, provides additional child care when Christopher's parents are unavailable. His parents describe Ms. Rockwell as "very caring" but "a bit domineering." They say they have encouraged her to occupy Christopher's time with "playful distractions."

Christopher was described by his parents as "a rather sickly child with a host of respiratory and digestive ailments" that precluded physical activity. Therefore, much of his early childhood was spent indoors in the company of either the nanny or one or two "chosen" playmates, but mostly with his "precious stuffed animals." In a separate interview, Ms. Rockwell noted that Christopher "could virtually spend hours engaged in fanciful adventures with this ragamuffin band." Not only did Christopher play with his stuffed friends, he would draw pictures of them, fashion clothing out of paper to protect them from the elements, and would at times attempt to take them into the bath with him. Christopher's connection with his "stuffed friends" became more problematic when at 5½ years of age he began kindergarten at the Blustershire School for the Gifted and Creative.

According to his kindergarten teacher at Blustershire, Christopher was a very pleasant, creative, and easygoing child who had difficulty making friends but who "easily won the hearts of teachers." He was a child who cried easily when his stuffed toys were taken away during other class activities and who withdrew from others. During times when he was separated from his animals, he would sit alone in a corner and draw, suck his thumb, have conversations with absent imaginary friends, and occasionally rock back and forth. Although Christopher successfully met the academic criteria for passage into the first grade, his parents and teachers were concerned that due to his lack of social interest and his overly restricted interests in his toys, he would need a smaller classroom environment for first grade than could be provided by Blustershire. As a result, he was transferred to the Hundred Acre Day School for Boys.

Problem and Counseling History. Christopher was referred to the school guidance center by the school counselor and headmistress out of concern that his growing preoccupation with his imaginary friends and socially isolative behavior might be suggestive of incipient psychological disorder. Due to his known behavior, the school counselor asked ahead of time that Christopher bring one or two of his favorite stuffed animals with him.

Christopher presented as a slender, yet healthy-looking child with fair skin, blue eyes, and blond hair, who sported a stuffed animal under each arm. He introduced one as his favorite, Winnie, a bear, and the other as Winnie's best friend, Tigger, a threadbare tiger. Christopher sat throughout the interview engaged primarily in play with his toys. However, when asked by the counselor, he shared adventures that he has had with Winnie, Tigger, and his other friends. Given the opportunities, he drew pictures of his imaginary Hundred Acre Wood and pleasantly chatted about his favorite, Winnie the Pooh, but made little eye contact with the counselor. When asked about his being at the school, Christopher said that "I like it well enough, but I miss my room at home." Christopher became particularly animated only when discussing his most recent adventure with his friends.

Goals for Counseling and Course of Therapy to Date. As a result of the initial meeting with the school counselor, it was recommended that Christopher be referred for a play assessment and the development of a plan for play therapy and other developmentally appropriate treatment with the school's psychological consultant, Dr. Gleewell, a certified child counselor specializing in creative expression. Dr. Gleewell would use a variety of expressive materials, including a sandtray, puppets, arts and crafts, as well as metaphoric storytelling in order to determine any possible underlying psychological issues that might be contributing to Christopher's behavior; and to intervene with treatment. The primary goal of additional evaluation and treatment is to promote the client's ability to remain enrolled at and be successful at the Day School. Specific objectives will be determined.

Diagnostic Impressions

299.00 (F84.0) Autism Spectrum Disorder, Requiring Support, Without

Accompanying Intellectual Impairment, Without Accompanying Language Impairment**;** Early childhood respiratory and digestive problems.

Other factors: V62.3 (Z55.9) Academic or educational problem—Problems adjusting to educational environment.

Discussion of Diagnostic Impressions

Christopher Robin was referred to the school guidance center because the school staff had become worried about his social isolation and inordinate preoccupation with his imaginary friends. According to reports by his teachers and parents, Christopher's primary engagement was with his Hundred Acre Wood stuffed animals. They described his focus on his animals as an almost all-encompassing preoccupation. In fact, when separated from his toys of interest, he had imaginary conversations with them, sat alone and drew pictures of them, and rocked. His teachers and parents also reported that outside of his interest in his toys, Christopher exhibited almost no interest in playing with or otherwise engaging his classmates, neighborhood children, or other peers; and he made very little eye contact with them or with adults such as his teachers and housekeeper. In fact, he paid very little attention to others.

The Neurodevelopmental Disorders chapter is a wide-reaching section of the *DSM-5* and is organized into many groupings of disorders that all share the feature of early developmental deficits. One diagnosis found in the grouping known as Autism Spectrum Disorder, describes a combination of developmental disorders previously in the *DSM-IV-TR,* including Autistic Disorder, Asperger's Disorder, childhood disintegrative disorder, and Pervasive Developmental Disorder Not Otherwise Specified (APA, 2013). Increasingly, being able to identity, evaluate, diagnose, and provide treatment and support for students with Autism Spectrum Disorder are important clinical skills for counseling professionals who work with children, adolescents, young adults, and adults in school, college and university, and community settings (Adreon & Durocher, 2007; Van Bergeijk, Klin, & Volkmar, 2008).

In our imagined case, Christopher Robin presented impaired development in social interaction and restricted interests and activities. Although he preferred to be isolated, Christopher had no significant delay in

language development. Similarly, no other developmental delays in cognition or other age-appropriate skills were noted outside of his lack of social interaction and lack of interest in the world around him. In such cases of restricted, stereotypical, consuming interests, and impaired social interactions in the absence of delays in language or other cognitive development, the diagnosis is Autism Spectrum Disorder, with a Level 1 severity specifier of "Requiring support" (APA, 2013, p. 52).

Regarding differential diagnoses, a more severe specifier, such as Level 2 ("Requiring substantial support") or Level 3 ("Requiring very substantial support") might be considered. However, the more severe specifiers typically indicate a more significant delay or impairment in early language development or cognition and a need for intervention with social communication skills and restricted, repetitive behaviors, neither of which apply to Christopher at this stage in his development.

To wrap up the diagnosis, Christopher's physical health problems are listed alongside his primary mental health diagnosis, and his school stress is emphasized in the "Other factors" section. This additional information is consistent with the primary diagnosis describing Christopher's patterns of behavior.

Case Conceptualization

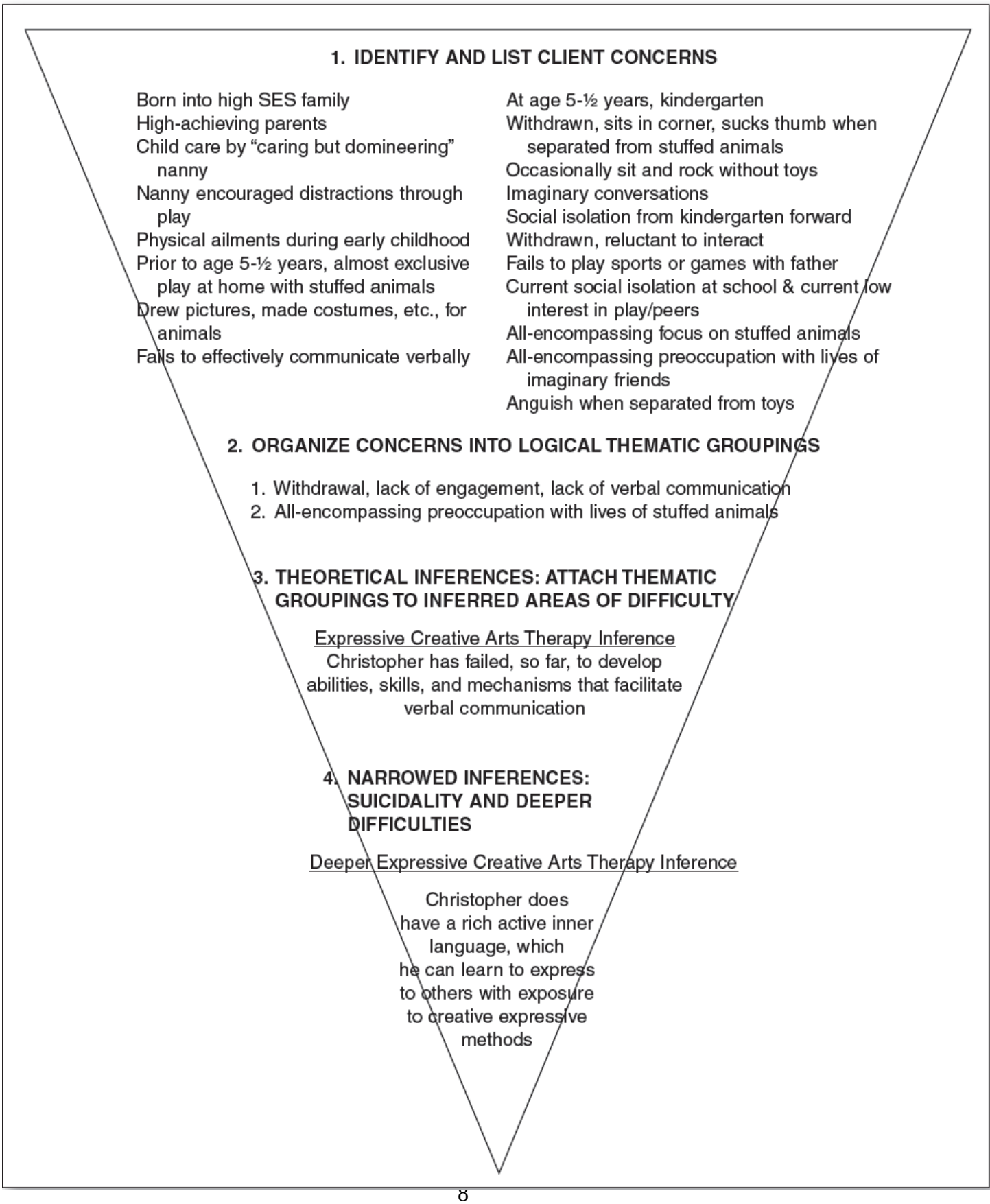
When Christopher Robin came to counseling, first he participated in an evaluation session. The intake counselor collected as much information as possible about the problematic situations in class and outside of class that led to Christopher's referral by his teachers, parents, and other adults at school. The counselor first used evaluation information to develop diagnostic impressions. Christopher's concerns were described by Autism Spectrum Disorder. Next, the counselor developed a case conceptualization. Whereas the purpose of diagnostic impressions is to *describe* the client's concerns, the goal of case conceptualization is to better *understand* and clinically *explain* the person's experiences (Neukrug & Schwitzer, 2006). It helps the counselor understand the etiology leading to Christopher's presenting concerns and the factors maintaining these behaviors. In turn, case conceptualization sets the stage for treatment planning. Treatment planning then provides a road map that plots out how the counselor and client expect to move from presenting concerns to positive outcomes (Seligman,

1993, p. 157)—helping Christopher increase his abilities to socialize more appropriately and engage in "real-world" activities and interests.

When forming a case conceptualization, the clinician applies a purist counseling theory, an integration of two or more theories, an eclectic mix of theories, or a solution-focused combination of tactics, to his or her understanding of the client. In this case, Christopher's counselor based her conceptualization on a purist theory applicable to the behavioral needs of child clients, the Expressive Creative Arts Approach to play therapy and counseling with children. She selected this approach based on her knowledge of current outcome research and the best practice literature pertaining to child clients dealing with the Autism spectrum and especially communication problems (Gladding, 2005; Kazdin & Weisz, 2003; Mowder, Rubinson, & Yasik, 2009; Vernon & Clemente, 2005). The Expressive Creative Arts Approach is consistent with this counselor's professional therapeutic viewpoint about clinical work with child and early adolescent clients.

The counselor used the Inverted Pyramid Method of case conceptualization because this method is especially designed to help clinicians more easily form their conceptual pictures of their clients' needs (Neukrug & Schwitzer, 2006; Schwitzer, 1996, 1997). The method has four steps: Problem Identification, Thematic Groupings, Theoretical Inferences, and Narrowed Inferences. The counselor's clinical thinking can be seen in the figure that follows.

Christopher Robin's Inverted Pyramid Case Conceptualization Summary: Expressive Creative Arts Play Therapy



Step 1: Problem Identification. The first step is Problem Identification. Aspects of the presenting problem (thoughts, feelings, behaviors, physiological features), additional areas of concern besides the presenting concern, family and developmental history, in-session observations, clinical inquiries (medical problems, medications, past counseling, substance use, suicidality), and psychological assessments (problem checklists, personality inventories, mental status exam, specific clinical measures) all may contribute information at Step 1. The counselor "casts a wide net" in order to build Step 1 as exhaustively as possible (Neukrug & Schwitzer, 2006, p. 202). As can be seen in the figure, the counselor thoroughly noted not just all of Christopher's verbal expressive concerns, social isolation, and aspects of his preoccupation with his imaginary animals, and so on—but also, as much important information as she could find regarding his developmental experiences and inner experience. She attempted to go beyond just listing the main behaviors causing the referral and to be as complete as she could.

Step 2: Thematic Groupings. The second step is Thematic Groupings. The clinician organizes all of the exhaustive client information found in Step 1 into just a few intuitive-logical clinical groups, categories, or themes, on the basis of sensible common denominators (Neukrug & Schwitzer, 2006). Four different ways of forming the Step 2 theme groups can be used: Descriptive-Diagnosis Approach, Clinical Targets Approach, Areas of Dysfunction Approach, and Intrapsychic Approach. As can be seen in the figure, Christopher's counselor selected the Areas of Dysfunction Approach. This approach sorts together all of the Step 1 information into "areas of dysfunction according to important life situations, life themes, or life roles and skills" (Neukrug & Schwitzer, 2006, p. 205).

The counselor grouped together (a) his obstacles to verbal expression, social isolation, withdrawal, and so on into the theme "Withdrawal, lack of engagement, lack of verbal communication" as well as (b) his preoccupied behaviors with his animal toys, focus on his imaginary friends' lives, separation symptoms, and so on into the theme "All-encompassing preoccupation with lives of stuffed animals." She evaluated these two areas to be related but separate themes. Her conceptual work at Step 2 gave the counselor a way to begin understanding and organizing Christopher's areas of functioning of concern more clearly and meaningfully.

So far, at Steps 1 and 2, the counselor has used her clinical assessment skills and her clinical judgment to begin meaningfully understanding Christopher's needs. Now, at Steps 3 and 4, she applies the theoretical approach she has selected. She begins making theoretical inferences to interpret and explain the processes or roots underlying Christopher's concerns as they are seen in Steps 1 and 2.

Step 3: Theoretical Inferences. At Step 3, concepts from the counselor's selected theory, Expressive Creative Arts Therapy, are applied to explain the aspects of Christopher's problematic behaviors. The counselor tentatively matches the theme groups in Step 2 with this theoretical approach. In other words, the symptom constellations in Step 2, which were distilled from the symptoms in Step 1, now are combined using theory to show what is believed to be the underlying etiology of Christopher's current needs (Neukrug & Schwitzer, 2006; Schwitzer, 2006, 2007).

The Expressive Creative Arts Therapy approach is based on the assumption that verbal approaches to engagement and relationship with some children are limited and ineffective, especially with children who—based on their developmental predispositions, earlier experiences, or other neurological and psychosocial factors—are reluctant to communicate through traditional verbal means (Gladding, 2005; Okun, 2007; Vernon & Clemente, 2005). According to the model, children with such difficulties verbally communicating have not yet developed sufficient skills and coping mechanisms and therefore may benefit from art-oriented or other creative expression-oriented methods of engaging and sharing their needs and inner lives (Gladding, 1995, 2005; Lev-Wiesel & Daphna-Tekoha, 2000).

As can be seen in the figure, when the counselor applied these Expressive Creative Arts Therapy constructs, she made one theoretical inference at Step 3 to explain the issues identified in Step 1, leading to the themes at Step 2: Christopher has failed, so far, to develop abilities, skills, and mechanisms that facilitate verbal communication. This is presented in the figure.

Step 4: Narrowed Inferences. At Step 4, the clinician's selected theory continues to be used to address still-deeper issues when they exist (Schwitzer, 2006, 2007). At this step, "still-deeper, more encompassing, or more central, causal themes" are formed (Neukrug & Schwitzer, 2006, p. 207). Continuing to apply Creative

Expressive Arts Therapy concepts at Step 4, Christopher's counselor presented a single, most-fundamental construct that she believed to be most explanatory Christopher's needs. This was a deeper inference that Christopher does have a rich, active inner language that he can learn to express to others with exposure to creative expressive methods. When all four steps are completed, the client information in Step 1 leads to logical-intuitive groupings on the basis of common denominators in Step 2, the groupings then are explained using theory at Step 3, and then, finally, at Step 4, further deeper explanations are made. From start to finish, the thoughts, feelings, behaviors, and physiological features in the topmost portions are connected on down the pyramid into deepest dynamics.

The completed pyramid now is used to plan the treatment and techniques that will be employed in work with Christopher Robin as we have portrayed him in this case.

Treatment Planning

At this point, Christopher's clinician at the Hundred Acre Day School Counseling Center has collected all available information about the problems that have been of concern to his family and school. Based upon this information, the counselor developed a *DSM-5* diagnosis and then, using the "inverted pyramid" (Neukrug & Schwitzer, 2006; Schwitzer, 1996, 1997), formulated a working clinical *explanation* of Christopher's difficulties and their etiology that we called the *case conceptualization.* This, in turn, guides us to the next critical step in our clinical work, called the *treatment plan*, the primary purpose of which is to map out a logical and goal-oriented strategy for making positive changes in the client's life. In essence, the treatment plan is a road map "for reducing or eliminating disruptive symptoms that are impeding the client's ability to reach positive mental health outcomes" (Neukrug & Schwitzer, 2006, p. 225). As such, it is the cornerstone of our work with not only Christopher, but with all clients who present with disturbing and disruptive symptoms and patterns (Jongsma & Peterson, 2006; Jongsma, Peterson, & McInnis, 2003a, 2003b; Seligman, 1993, 1998, 2004).

A comprehensive treatment plan must integrate all of the information from the biopsychosocial interview, diagnosis, and case conceptualization into a coherent plan of action. This *plan* comprises four main

components, which include (1) a behavioral definition of the problem(s), (2) the selection of achievable goals, (3) the determination of treatment modes, and (4) the documentation of how change will be measured. The *behavioral definition of the problem(s)* consolidates the results of the case conceptualization into a concise hierarchical list of problems and concerns that will be the focus of treatment. The *selection of achievable goals* refers to assessing and prioritizing the client's concerns into a *hierarchy of urgency* that also takes into account the client's motivation for change, level of dysfunction, and real-world influences on his or her problems. The *determination of treatment modes* refers to selection of the specific interventions, which are matched to the uniqueness of the client and to his or her goals and clearly tied to a particular theoretical orientation (Neukrug & Schwitzer, 2006). Finally, the clinician must establish how change will be measured, based upon a number of factors, including client records and self-report of change, in-session observations by the clinician, clinician ratings, results of standardized evaluations such as the Conners 3 (Conners, 2008b) or a family functioning questionnaire, pre-post treatment comparisons, and reports by other treating professionals.

The four-step method discussed above can be seen in the text and is outlined below for the case of Christopher, followed by his specific treatment plan.

Step 1: Behavioral Definition of Problems. The first step in treatment planning is to carefully review the case conceptualization, paying particular attention to the results of Step 2 (Thematic Groupings), Step 3 (Theoretical Inferences), and Step 4 (Narrowed Inferences). The identified clinical themes reflect the core areas of concern and distress for the client, while the theoretical and narrowed inferences offer clinical speculation as to their origins. In the case of Christopher, there are two primary areas of concern. The first, "withdrawal, lack of engagement and verbal communication," refers to isolative behavior at home and at school, reluctance to interact, failure to play sports and games with his father, low interest in play with peers, and occasional sitting and rocking without toys. The second, "all encompassing preoccupation with the lives of his stuffed animals," refers to almost exclusive play at home and conversations with stuffed animals, drawing pictures of and making costumes for stuffed animals, and all-encompassing focus on stuffed animals and their imaginary lives. These symptoms and stresses are consistent with the diagnosis of Autism Spectrum Disorder (APA, 2013; Hersen &

Ammerman, 2000; Kundert & Trimarchi, 2006; Meyer, Mundy, Van Hecke, & Durocher, 2006; Parritz & Troy, 2011).

Step 2: Identify and Articulate Goals for Change. The second step is the selection of achievable goals, which is based upon a number of factors, including the most pressing or urgent behavioral, emotional, and interpersonal concerns and symptoms as identified by the client and clinician, the willingness and ability of the client to work on those particular goals, and the realistic (real-world) achievability of those goals (Neukrug & Schwitzer, 2006). At this stage of treatment planning, it is important to recognize that not all of the client's problems can be addressed at once, so we focus initially on those that cause the greatest distress and impairment. New goals can be created as old ones are achieved. In the case of Christopher, the goals are divided into two prominent areas. The first, "withdrawal, lack of engagement and verbal communication," requires that we help Christopher strengthen his basic (external) expressive language skills and the ability to communicate simply with others, increase the frequency of positive interactions with parents and peers, strengthen the basic emotional bond with his parents, engage in reciprocal and cooperative interactions with others on a regular basis, and help his parents, teachers, and peers develop a level of understanding and acceptance of Christopher's capabilities and set realistic expectations for his behavior. The second, "solitary, repetitive, stereotypical, and purposeless behaviors and play," requires that we help Christopher reduce the amount of time that he engages in play with stuffed animals, shape and reinforce play with other toys and materials, increase the frequency of play with parents and peers, and attain the highest, most realistic level of overall functioning.

Step 3: Describe Therapeutic Interventions. This is perhaps the most critical step in the treatment planning process because the clinician must now integrate information from a number of sources, including the case conceptualization, the delineation of the client's problems and goals, and the treatment literature, paying particular attention to *empirically supported treatment* (EST) and *evidence-based practice* (EBP). In essence, the clinician must align his or her treatment approach with scientific evidence from the fields of counseling and psychotherapy. Wampold (2001) identifies two types of evidence-based counseling research: studies that demonstrate "absolute efficacy," that is, the fact that counseling and psychotherapy work, and those that

demonstrate “relative efficacy,” that is, the fact that certain theoretical/technical approaches work best for certain clients with particular problems (Psychoanalysis, Gestalt Therapy, Cognitive Behavior Therapy, Brief Solution-Focused Therapy, Cognitive Therapy, Dialectical Behavior Therapy, Person-Centered Therapy, Expressive/Creative Therapies, Interpersonal Therapy, and Feminist Therapy; and when delivered through specific treatment modalities (individual, group, and family counseling).

In the case of Christopher, we have decided to use an eclectic play-based/expressive-artistic intervention based upon child-centered and cognitive behavioral play therapy as well as Social Stories and Lego Therapy. It is important to note that “specific interventions proposed for clinical disturbances . . . have included individual psychotherapy for the child and/or caregiver, parent training with emphasis on developmental expectations and sensitive responsiveness, family therapy or caregiver/child dyadic therapy” (Zeanah & Boris, 2005, p. 365). Child-Centered Play Therapy (CCPT) is a humanistic and nondirective approach to child counseling that derives from the work of Carl Rogers (Rogers, 1951, 1961) and Virginia Axline (1947). It is based upon the premise that children have an inherent capacity for self-understanding, self-expression, positive relationships, and mental health, which can be nurtured and facilitated under the therapeutic conditions of attuned empathy congruence and unconditional positive regard. In the nonjudgmental and nonhurried playspace that provides the child access to toys, materials, and activities for the full expression of thoughts, feelings, and behaviors, he or she can work through conflicts and gain self-acceptance and effective coping skills for living in the world (Landreth, 2002; Moustakas, 1959; Nordling, Cochran, & Cochran, 2010). It has been effectively applied to a wide range of child behavior and emotional problems, including the symptoms of Autism Spectrum Disorder (Baggerly, Ray, & Bratton, 2010; VanFleet, Sywulak, Caporaso, Sniscak, & Guerney, 2010). Specific techniques that will be drawn from this approach will include utilizing unconditional positive regard, acceptance, attuned empathy, focused tracking, and selective limit-setting with Christopher as he engages with the different materials and activities in the playroom (arts-and-crafts, puppets, dollhouse, drawing, storytelling, role-playing).

Cognitive Behavior Play Therapy was originally devised as a means of applying the empirically proven methods of cognitive and behavior therapy to working with children, particularly in the playroom (Knell, 1993, 1994). This approach relies on a variety of cognitive techniques (reframing, challenging irrational thoughts, and cognitive restructuring) and behavioral techniques (reinforcement for and shaping of adaptive behavior, extinction of maladaptive behaviors, systematic desensitization, exposure with response prevention). However, the cognitive behavioral play therapist also uses artistic and expressive playroom materials, such as board games, puppets, dolls, drawings, storytelling, and the sandtray to achieve these ends. An example would be engaging a child through the use of puppets in a conversation about feelings and relating with others while verbalizing possible thoughts that impair social relatedness. This technique has been effectively applied to a variety of childhood emotional and behavioral problems, including symptoms of Autism Spectrum Disorder (Drewes, 2009). Specific techniques drawn from this approach will include using puppets and role play in a group play format to address Christopher's social disinterest, shaping social behavior through sandtray miniature play, and creating cartoon strip stories around the themes of withdrawal and positive engagement.

More recently, creative techniques, that is, those that employ art, music, dance, drama, and play, have been used to enhance sensory integration, social skills, communication, and symbolic thinking. Social Stories (Gray & Garand, 1983) is one such methodology that relies upon the use of picture stories to teach social problem-solving skills and it has been found to be useful in working with children with Autism Spectrum Disorder (Kokina & Kern, 2010). Another play-based intervention that has been found to be both useful and effective with these children is Lego therapy (LeGoff, 2004), which uses Legos to teach social skills. Lego toys are naturally attractive and sensorily appealing and as such can capture the attention of children with Autism Spectrum Disorder for long periods. The play therapist works with children individually or in groups to build Lego-based social scenarios through which clients can interact. In Christopher's case, we will use elements of both Social Stories and Lego therapy to enhance his social and communication skills.

Finally, and in working directly with Christopher's parents, we will provide psychoeducational support so that they may understand the manifestations of Autism Spectrum Disorder and refer them to an autism

support group and encourage them to join the Autism Society of London to expand their knowledge and support.

Step 4: Provide Outcome Measures of Change. This last step in treatment planning requires that we specify how change will be measured and indicate the extent to which progress has been made toward realizing these goals (Neukrug & Schwitzer, 2006). The counselor has considerable flexibility in this phase and may choose from a number of objective domains (psychological tests and measures of self-esteem, depression, psychosis, interpersonal relationship, anxiety, etc.), quasi-objective measures (pre-post clinician, client and psychiatric ratings), and subjective ratings (client self-report, clinician's in-session observations). In Christopher's case, we have implemented a number of these, including clinician- and parent-reported improvement in verbal communication, social interaction and creative/expressive play; teacher-reported increased frequency of decreased isolative play and increased interactive play; and clinician- and parent-reported improvement in verbal communication, social interaction, and creative/expressive play, with materials and objects in addition to stuffed animals.

The completed treatment plan is now developed through which the counselor, Christopher, and his parents and teachers will begin their shared work of improving his social communication skills, reducing the amount of time playing with his stuffed animals, increasing the amount of social play, and connecting his parents with Autism spectrum support. The treatment plan is described below and is summarized in the table that follows.

TREATMENT PLAN

Client: Christopher Robin

Service Provider: Hundred Acre Day School Counseling Center

BEHAVIORAL DEFINITION OF PROBLEMS:

1. Withdrawal, lack of engagement and verbal communication—Isolative behavior at home and at school, reluctance to interact, failure to play sports and games with his father, low interest in play with peers, and

occasional sitting and rocking without toys

2. All-encompassing preoccupation with lives of stuffed animals—Almost exclusive play at home and conversations with stuffed animals, drawing pictures of and making costumes for stuffed animals, and all-encompassing focus on stuffed animals and their imaginary lives

---

GOALS FOR CHANGE:

1. Withdrawal, lack of engagement, and verbal communication

- Strengthen basic expressive language skills
- Strengthen ability to communicate simply with others
- Strengthen the basic emotional bond with his parents
- Increase the frequency of positive interactions with parents and peers
- Engage in reciprocal and cooperative interactions with others on a regular basis
- Help his parents, teachers, and peers to develop a level of understanding and acceptance of capabilities and set realistic expectations for behavior

2. All-encompassing preoccupation with lives of stuffed animals

---

- Reduce the amount of time engaging in play with stuffed animals
- Shape and reinforce play with other toys and materials
- Increase the frequency of play with parents and peers
- Attain the highest, most realistic level of overall functioning

THERAPEUTIC INTERVENTIONS:

An ongoing course of eclectic play-based/expressive-artistic intervention targeting psychological and social/interpersonal deficiencies supplemented with psychoeducation and group support for parents and teachers

---

1. Targeting psychological factors (solitary play with stuffed animals)

- Using unconditional positive regard, acceptance, attuned empathy, focused tracking, and selective limit-setting in the therapeutic playroom with different materials and activities (arts-and-crafts, puppets, dollhouse, drawing, storytelling, role-

playing)

- Use effective contingency management to decrease repetitive and preoccupied play with stuffed animals
- Extinguish repetitive stuffed-animal play by reinforcing engagement with a broader array of play materials and activities
- Use Social Stories in individual counseling to stimulate social interest
- Use Legos in group counseling to build social interest and interaction

2. Targeting social interactions and communication

- Using unconditional positive regard, acceptance, attuned empathy, focused tracking, and selective limit-setting in the therapeutic playroom with other children using different materials and activities (arts-and-crafts, puppets, dollhouse, drawing, storytelling, role-playing)
- Employ frequent use of praise and positive reinforcement to increase verbalizations and social communication
- Use a token economy at home and in the school to build interactive play and social communication skills
- Implement a response-shaping program to facilitate his communicative language and social interaction skills
- Use Social Stories in individual counseling to stimulate social interest
- Use Legos in group counseling to build social interest and interaction

3. Targeting parenting

- Referral to an Autism support group
- Encouragement to join the Autism Society of London to expand knowledge and support base
- Psychoeducational support

OUTCOME MEASURES OF CHANGE:

Decreased preoccupation with stuffed-animal play, increased play with other objects and materials, and increased social interaction as measured by:

- Clinician- and parent-reported improvement in verbal communication, social interaction, and creative/expressive play
- Teacher-reported increased frequency of decreased isolative play and increased interactive play
- Clinician-observed play with materials and objects in addition to stuffed animals

Christopher Robin's Treatment Plan Summary: Expressive Creative Arts Play Therapy

Goals for Change	*Therapeutic Interventions*	*Outcome Measures of Change*
Withdrawal, lack of engagement and verbal communication Strengthen basic expressive language skills Strengthen ability to communicate simply with others Strengthen the basic emotional bond with his parents Increase the frequency of positive interactions with parents and peers Engage in reciprocal and cooperative interactions with others on a regular basis Help his parents, teachers, and peers develop a level of understanding and acceptance of capabilities and set realistic expectations for behavior **All-encompassing preoccupation with lives of stuffed animals** Reduce the amount of time engaging in play with stuffed	**Targeting psychological factors (solitary play with stuffed animals)** Using unconditional positive regard, acceptance, attuned empathy, focused tracking, and selective limit-setting in the therapeutic playroom with different materials and activities (arts-and-crafts, puppets, dollhouse, drawing, storytelling, role-playing) Use effective contingency management to decrease repetitive and preoccupied play with stuffed animals Extinguish repetitive stuffed-animal play by reinforcing engagement with a broader array of play materials and activities Use Social Stories in individual counseling to stimulate social interest Use Legos in group counseling to build social interest and interaction **Targeting social interactions and communication** Using unconditional positive regard, acceptance, attuned empathy, focused tracking, and selective limit-setting in the therapeutic playroom with different materials and activities (arts-and-crafts, puppets, dollhouse, drawing, storytelling,	**Decreased preoccupation with stuffed-animal play, increased play with other objects and materials, and increased social interaction as measured by:** Clinician- and parent-reported improvement in verbal communication, social interaction, and creative/expressive play Teacher-reported increased frequency of decreased isolative play and increased interactive play Clinician-observed play with materials and objects in addition to stuffed animals

animals Shape and reinforce play with other toys and materials Increase the frequency of play with parents and peers Attain the highest, most realistic level of overall functioning	role-playing) Employ frequent use of praise and positive reinforcement to increase verbalizations and social communication Use a token economy at home and in the school to build interactive play and social communication skills Implement a response-shaping program to facilitate his communicative language and social interaction skills Use Social Stories in individual counseling to stimulate interest Use Legos in group counseling to build social interest and interaction **Targeting parenting** Referral to an Autism support group Encouragement to join the Autism Society to expand knowledge and support base Psychoeducational support	

References

Adreon, D., & Durocher, J. S. (2007). Evaluating the college transition needs of individuals with high-functioning autism spectrum disorders. *Intervention in School and Clinic, 42,* 271–279.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Axline, V. (1947). *Play therapy.* New York, NY: Ballantine.

Baggerly, J., Ray, D., & Bratton, S. (2010). *Child-centered play therapy research: The evidence base for effective practice.* New York, NY: Wiley.

Conners, C. K. (2008a). *Attention deficit hyperactivity disorder: The latest assessment and treatment strategies* (3rd ed.). Sudbury, MA: Jones & Bartlett Learning.

Conners, C. K. (2008b). *Conners 3rd edition: Manual.* North Tanawanda, NY: Multi Health Systems.

Drewes, A. (2009). *Blending play therapy with cognitive-behavior therapy: Evidence-based and other effective treatments and techniques.* Hoboken, NJ: Wiley.

Gladding, S. (1995). Creativity in counseling. *Counseling and Human Development, 28,* 1–12.

Gladding, S. (2005). *Counseling as art: The creative arts in counseling* (3rd ed.). Alexandria, VA: American Counseling Association.

Gray, C., & Garand, D. (1983). Social stories: Improving responses of students with autism with accurate social information. *Focus on Autism and Other Developmental Disabilities, 8*(April), 1–10.

Hersen, M., & Ammerman, R. (2000). *Advanced abnormal child psychology.* Mahwah, NJ: Lawrence Erlbaum.

Jongsma, A., & Peterson, L. M. (2006). *The complete adult psychotherapy treatment planner.* New York, NY: Wiley.

Jongsma, A., Peterson, L. M., & McInnis, W. (2003a). *The adolescent psychotherapy treatment planner.* New York, NY: Wiley.

Jongsma, A., Peterson, L. M., & McInnis, W. (2003b). *The child psychotherapy treatment planner.* New York, NY: Wiley.

Kazdin, A. E., Weisz, J. (Eds.). (2003). *Evidence-based psychotherapies for children and adolescents.* New York, NY: Guilford Press.

Knell, S. (1993). *Cognitive-behavioral play therapy.* Northvale, NJ: Jason Aronson.

Knell, S. (1994). Cognitive-behavioral play therapy. In K. O'Conner & C. Schafer (Eds.), *Handbook of play therapy: Vol 2. Advances and innovations* (pp. 111–142). New York, NY: Wiley.

Kokina, A., & Kern, L. (2010). Social Story™, Interventions for students with autism spectrum disorders: A meta-analysis. *Journal of Autism and Developmental Disorders, 40*(7), 812–826.

Landreth, G. (2002). *Play therapy: The art of the relationship.* Muncie, IN: Accelerated Development.

LeGoff, D. (2004). Use of Lego as a therapeutic medium for improving social competence. *Journal of Autism and Developmental Disorders, 34*(5), 557–571.

Lev-Wiesel, R., & Daphna-Tekoha, S. (2000). The self-revelation through color technique: Understanding clients' relationships with significant others through the use of color. *American Journal of Art Therapy, 39,* 35–41.

Meyer, J. A., Mundy, P. C., van Hecke, A. V., & Durocher, J. S. (2006). Social attribution processes and comorbid psychiatric symptoms in children with Asperger's syndrome. *Autism, 10,* 383–402.

Moustakas, C. E. (1959). *Psychotherapy with children.* New York, NY: Harper & Row.

Mowder, B., Rubinson, F., & Yasik, A. (Eds.). (2009). *Evidence-based practice in infant and early childhood psychology.* New York, NY: Wiley.

Neukrug, E. S., & Schwitzer, A. M. (2006). *Skills and tools for today's counselors and psychotherapists: From natural helping to professional helping.* Belmont, CA: Wadsworth/Thomson Brooks/Cole.

Nordling, W., Cochran, J., & Cochran, N. (2010). *A practical guide to developing therapeutic relationships with children.* New York, NY: Wiley.

Okun, B. F. (2007). *Effective helping, interviewing, and counseling techniques* (7th ed.). Pacific Grove, CA: Brooks/Cole.

Parritz, R. H., & Troy, M. (2011). *Disorders of childhood: Development and psychopathology.* New York, NY: Wadsworth.

Reitherman, W. (Director). (1968). *Winnie the Pooh and the blustery day* [Motion Picture]. United States: Walt Disney Productions.

Reitherman, W. (Producer), & Reitherman, W., & Lounsbery, J. (Directors). (1977). *The many adventures of Winnie the Pooh* [Motion Picture]. United States: Walt Disney Productions.

Rogers, C. (1951). *Client-centered therapy: Its current practice, implications and theory*. London: Constable.

Rogers, C. R. (1961). *On becoming a person.* Boston, MA: Houghton Mifflin.

Schwitzer, A. M. (1996). Using the inverted pyramid heuristic in counselor education and supervision. *Counselor Education and Supervision, 35,* 258–267.

Schwitzer, A. M. (1997). The inverted pyramid framework applying self psychology constructs to conceptualizing college student psychotherapy. *Journal of College Student Psychotherapy, 11*(3), 29–47.

Seligman, L. (1993). Teaching treatment planning. *Counselor Education and Supervision, 33*, 287–297.

Seligman, L. (1998). *Selecting effective treatments: A comprehensive systematic guide to treating mental disorders*. Upper Saddle River, NJ: Merrill/Prentice Hall.

Seligman, L. (2004). *Diagnosis and treatment planning* (3rd ed.). New York, NY: Plenum Press.

Van Bergeijk, E., Klin, A., & Volkmar, F. (2008). Supporting more able students on the autism spectrum: College and beyond. *Journal of Autism and Developmental Disorders, 38,* 1359–1370.

VanFleet, R., Sywulak, K. A., Caporaso, C., Sniscak, C. C., & Guerney, L. (2010). *Child-centered play therapy.* New York, NY: Guilford Press.

Vernon, A., & Clemente, R. (2005). *Assessment and intervention with children and adolescents: Developmental and multicultural considerations.* Alexandria, VA: American Counseling Association.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings.* Mahwah, NJ: Erlbaum.

Zeanah, C. H., & Boris, N. W. (2005). Disturbances and disorders of attachment in early childhood. In C. H. Zeanah, Jr. (Ed.), *Handbook of infant mental health* (pp. 353–368). New York, NY: Guilford Press.